The Modern Hospital

FEBRUARY 1957

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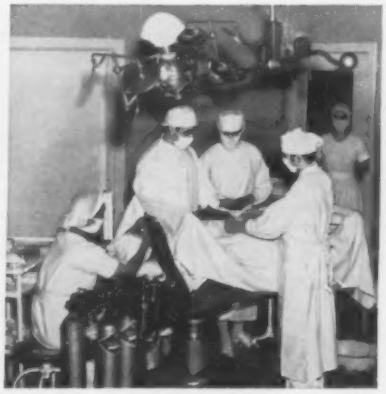

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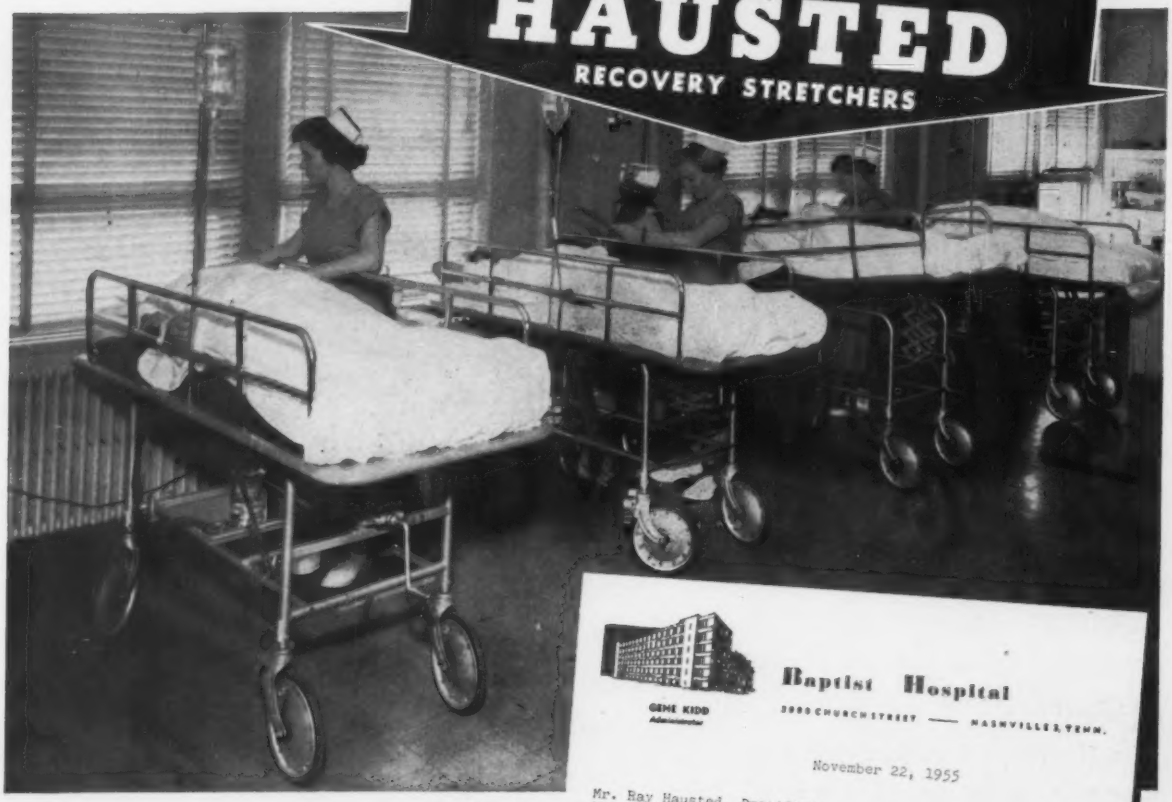

GENE KIDD
Administrator

Baptist Hospital

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November 22, 1955

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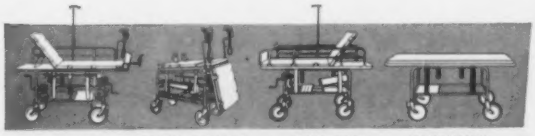

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The Modern Hospital

VOLUME 88, NO. 2

FEBRUARY 1957

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HOUSEKEEPING

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AMONG THE AUTHORS


George T. Nilson

A group of Waterville, Maine, men rises early every Sunday morning, not to golf, but to learn about medicine and surgery in a special two-hour seminar course at Thayer Hospital. These men have a deep interest in medical and surgical procedures. On page 71, **George T. Nilson** and **Paul W. Sternlof** describe the activities of SAPS (Society of Amateur Physicians and Surgeons). Mr. Nilson is health educator with the Bingham Associates Program assigned to the state of Maine. Besides representing the Bingham program, he is encouraging the development of lay health education activities among hospitals in the state. He is a graduate of the Harvard University School of Public Health.


Paul W. Sternlof

Paul W. Sternlof, co-author of the article about the Society of Amateur Physicians and Surgeons, is administrative resident at Thayer Hospital, Waterville, and New England Center Hospital in Boston. Mr. Sternlof is a graduate of Clark University and is a student in the hospital administration program at Yale University. He is a candidate for the degree of master of public health in June.


David J. Wires

David J. Wires sees no reason for not getting "big hospital" accounting into the small hospitals—and he tells why and how in an article about an accounting machine on page 75. By using the machine system Mr. Wires describes, accounting employes at Galion Community Hospital, Galion, Ohio, where he is administrator, can present discharged patients with complete, up-to-date bills at the time they leave the hospital. They also can keep track of expenditures and income in all departments for any given length of time. Before going to the Galion hospital, Mr. Wires was administrator of the 200 bed Children's Hospital in Cleveland. He's not out of his field in discussing accounting, either, since he also has been business administrator of Richland Hospital, Mansfield, Ohio.


Louise A. K. Frolich

Louise A. K. Frolich, who tries to help administrators avoid pitfalls in setting up food service operations in an article on page 114, was senior home economist for the Midwest Research Institute, Kansas City, Mo., at the time she prepared the paper. Miss Frolich has studied at the American University, Biarritz, France. She holds degrees of bachelor of science in dietetics and institution management from the University of Nebraska and master of arts in institution management from Teachers College, Columbia University. She also completed a dietetic internship at Henry Ford Hospital, Detroit. Miss Frolich currently is chairman of the college section of the American School Food Service Association. Since October 1956, she has been employed as food service specialist for Koch Refrigerators, Inc.

Gordon Davis is a public relations consultant for hospitals and Blue Cross, with offices in Birmingham, Mich., and Cleveland, where he began his career as a reporter and science writer for the *Cleveland Press.* His column on hospital public relations principles and problems, which will be a monthly feature in The MODERN HOSPITAL, begins this month on page 12.

ROVING REPORTER

Day Hospitals in Britain

Since day hospitals for the treatment of mental illness were first launched in England and Wales in 1951, their number has grown steadily. British experience over the last five years suggests that the day hospital has come to stay and that it has an increasingly useful part to play in the treatment of mental ill-health.

There are now some 20 day hospitals in England and Wales. The majority are attached to regular hospitals, and, as such, are part of the National Health Service. No attempt, however, has been made to create a uniform type, and day hospitals have developed on individual and different lines. Four major categories can be distinguished.

First is the day hospital, which is ancillary to an established mental hospital and which, because it shares all the regular hospital services, is the approximate equivalent of an additional ward. This development is expected to remain numerically the most important.

Second is the geriatric day hospital, attached either to a hospital for chronic diseases or to the geriatric department of a general hospital. Then there is the day hospital (which may also include a night hospital) run independently, with complete facilities for treatment on its own premises. This is, naturally, a more ambitious and costly project than the first two mentioned.

Finally, there is the center to which patients go at intervals during the week. This may be associated with a hospital, but it represents a new departure in the treatment of mental illness.

The day hospital attached to Maudsley Hospital, in southeast London, is fairly representative of the first type of development. It opened in 1953 in a four-story Victorian house not far from the main hospital buildings. It takes 30 patients. From the outset, there was a rigid rule that only those patients who would otherwise require treatment as inpatients would be admitted. Naturally, a second qualification is that the patient's home circumstances are such that he or she can remain at home while undergoing treatment.

The day hospital is run by the head of the outpatient department, who gives one or two sessions a week to it. The staff consists of a registrar, a staff nurse, and usually two student nurses. The patient's day is from 8:30 to 5 o'clock, lunch being provided.

In general, the daily routine is similar to that in the inpatient wards: occupational therapy in the mornings and a variety of community activities and discussions in the afternoons. A variation is that a nurse frequently takes groups of women out to do household shopping. Shopping helps patients to retain some sense of responsibility for their families and helps their families to get along more easily while they are under treatment.

The special advantages of the day hospital, in British experience, can be grouped under two heads: (1) medical and psychiatric, and (2) administrative.

Under the first head, an outstanding advantage is that patients can usually

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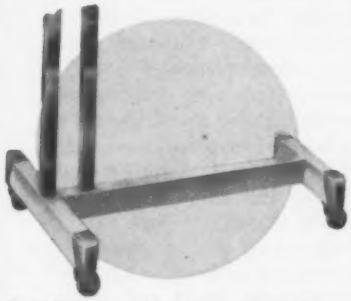

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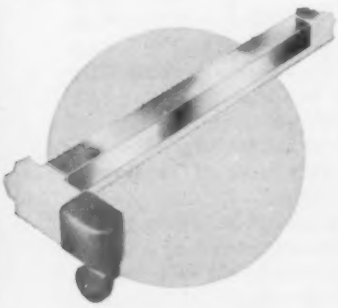
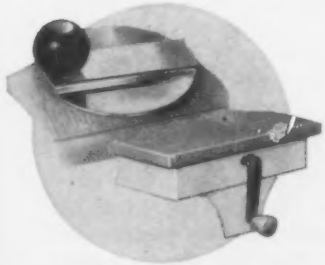


Optional stainless steel scuff plate reduces maintenance cost by protecting finish. Top crank model is available with chrome legs.



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be discharged earlier. A recent survey showed that, roughly speaking, the day patient's period of treatment is three weeks shorter than the inpatient's. This is largely because there is no need for the period of adjustment to ordinary life, which is essential for many inpatients.

At the same time, the day hospital takes care of that transition period for the discharged inpatient, forming the steppingstone between the ward and completely normal life. The same function is performed by the night hospital, with accommodation for 14 patients, now being set up in conjunction with the day hospital at the Maudsley. Here patients who are sufficiently well to go back to work but who still need the backing and support of the hospital return to sleep each night for a few months before resuming outside life entirely.

The day hospital also provides the answer in individual cases for those for whom orthodox inpatient treatment has been unsuccessful. At the Maudsley, there was a patient, separated from her husband, whose condition was aggravated by the fact that he was trying to get custody of the child. Had she become an inpatient, the husband would have had strong grounds for obtaining custody, and her recovery would probably have been impeded or delayed. As a day patient, she was able to continue to look after the boy when he came home from school, and she recovered reasonably quickly.

On the administrative and financial side, the advantages of a day hospital of this type are particularly striking. The initial outlay is considerably less than the cost of building a new ward to accommodate the same number of patients. Most day hospitals are housed, like Maudsley, in dwellings which can be acquired cheaply and need comparatively little adaptation.

The cost of treatment, as far as can be estimated, is also much lower. At the Maudsley, it costs £21 a week to treat and maintain an inpatient, and £7 a week to treat a day patient. Even taking into account the cost to the state (which pays for treatment and maintenance in hospitals like the Maudsley) of sick benefit, and special allowances made to patients living at home, the total is far less than £21. Naturally, the over-all cost also is reduced by the shorter period of treatment.

A totally different set of circumstances, medical and administrative, obtain at the center at Bromley, Kent, pioneered by a husband and wife, Dr. George Morgan and Dr. Elizabeth Tylden, who are in charge of the psychiatric clinic attached to Bromley General Hospital.

Dr. Morgan and Dr. Tylden had become convinced, from their talks with patients who had been in mental hospitals, of the considerable amount of help that mental patients could derive from one another. They had also become convinced that the ordinary sympathetic layman could contribute as much as, if not more, to the cure of mental cases than the trained worker. This was the basis on which they started the Stepping Stones Club, as the center attached to the clinic is called.

Three years ago, they got in touch with all the known former mental patients in the locality, or their relatives, and asked for volunteers to help run the proposed club. They were surprised to receive offers from about a hundred people, of whom a third were former mental patients.

These volunteers were given no pretraining; they were able to ask the doc-

tors or the psychiatric social workers for guidance when necessary, but generally speaking, common sense, sympathy and activity turned out to be ample qualifications. All the various activity groups of the club—dramatics, art, music, woodworking, canteen and handicrafts—are run and instructed by these volunteers. Only in the discussion groups led by Dr. Morgan and Dr. Tylden do qualified people take part. To date, all these groups have been meeting in the evenings in the homes of volunteer workers, but recently a house was acquired as premises for both clinic and club.

Some 200 adult cases a year are referred to the clinic and the Stepping Stones Club by general practitioners, hospital doctors, and mental hospitals. Approximately one-tenth of these are patients discharged from mental hospitals, who need to be tided over the transition period between the ward and normal life.

Originally Dr. Morgan and Dr. Tylden expected to treat neuroses almost exclusively, but they have found it also possible to treat psychotics by the same method of integration into a social unit. They have had considerable success with patients whom mental hospitals have been unable to cure.

No classification of patients into categories of mental illness is made; nor are patients ever segregated from normal people, either physically by walls, or, more subtly, by intensive sedative treatment. They are not cut off from normal life. The worst cases go first to Bromley Hospital for occupational therapy, and there mental and physical patients are mixed in one group. A mental patient may then begin to think that a blind man or a crippled woman is in a worse plight than himself, and such a realization may be the beginning of recovery.

Less seriously ill patients are asked what hobbies they have, what they would have liked to do had their circumstances been different, and what they were good at in school. From their answers it is decided which section or sections of the Stepping Stones Club they shall join. Each group is run on lines similar to an orthodox club, the great difference being that a mental patient would not join an orthodox club, and so would never have the benefit of community and creative activity.

Volunteer workers and patients mix freely in all these groups and in the four big socials held each year, and it is possible for a patient to be cured and leave the club without it ever being found out who was who. Patients and former patients sit, along with volunteer workers, on the extremely active committee (which the two doctors and the psychiatric social workers attend as observers without votes).

The fact that patients and workers are mixed in this way makes it easier to put those who have been cured in touch with regular voluntary organizations in the district. No one in the organization knows whether the new member has been a worker or a patient in the Stepping Stones Club.

Just as there is nothing formal or cut-and-dried about the treatment, there is nothing formal about either the administration or the finance of the Stepping Stones Club. The clinic attached to the hospital is financed by the National Health Service, but the club is not; such money as the club needs is raised entirely by voluntary subscriptions. — WENDY HALL, *London, England.*

A group of patients working on various occupational therapy projects in one of the 20 English day hospitals for the treatment of mental illness.

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HOSPITAL EQUIPMENT

The Heart and Mind Must Still Be Served

By GORDON DAVIS


Gordon Davis

YEARS ago when I first became concerned with the liaison between hospitals and the people they serve, it was the usual thing to hear protests that the hospitals' public relationships would take care of themselves.

All that was necessary was to serve the people well. Good public relations would then result automatically.

This argument is still heard, but it is disappearing. Beset with pressing problems of medical progress and expansion, most hospital leaders have become convinced that some effort to keep the public informed is essential.

For the most part, however, the new attitude is more instinctive than reasoned. It is recognized that there is much misunderstanding of hospitals—of their services, their problems, their needs, their costs. There is growing acceptance of the fact that public misunderstanding can limit and even reduce the ability to serve.

But true appreciation of the sources of misunderstanding is less common, and until this appreciation develops and matures into action, our hospitals will continue to meet public relations problems with which they cannot cope.

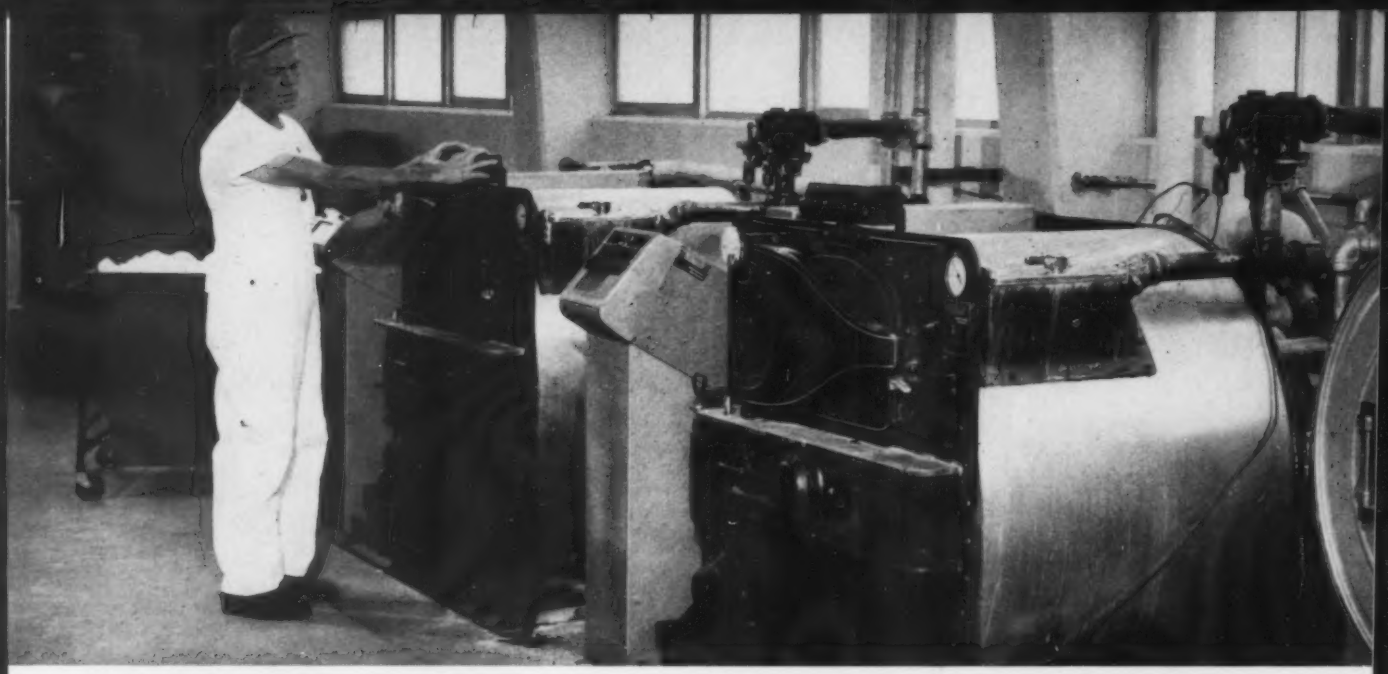
Public relations is not just a matter of public education. It is a means of establishing closer contact with the people. It must originate at the very top of the hospital hierarchy, with the administrator and the board, and it must be founded on complete comprehension of the basic function of public relations in the hospital scheme of things.

In broad terms, our hospitals need organized public relations today because of an ironic paradox in their development. Originating from the highest of spiritual motives, they have been forced by technological progress to subordinate the spiritual to the scientific, and in so doing they have reluctantly sacrificed much of their humanity. Where once they gave solace and comfort—and not much more—they now provide scientific therapy. Where once they were highly subjective in the care of patients, today they are almost wholly objective.

This is not to minimize the great achievements of science or the splendid accomplishments of the hospitals in turning scientific discovery to human good. It is merely to point out that, in the drive to extend their services to the human body, hospitals have been compelled to lessen the services they once gave to the heart and mind.

This is the realm of public relations. Because the original channels of communication between hospitals and the people have been disrupted, new channels must be developed. The communications activity will not be adequate if it is not organized and incorporated into administrative planning as carefully as any other hospital service.

Understanding between human beings—between the people who operate hospitals and the people for whom they are operated—is an inescapable ingredient of tomorrow's fuller service. Can anyone deny the need for this bond? Public relations is the activity which cements it.



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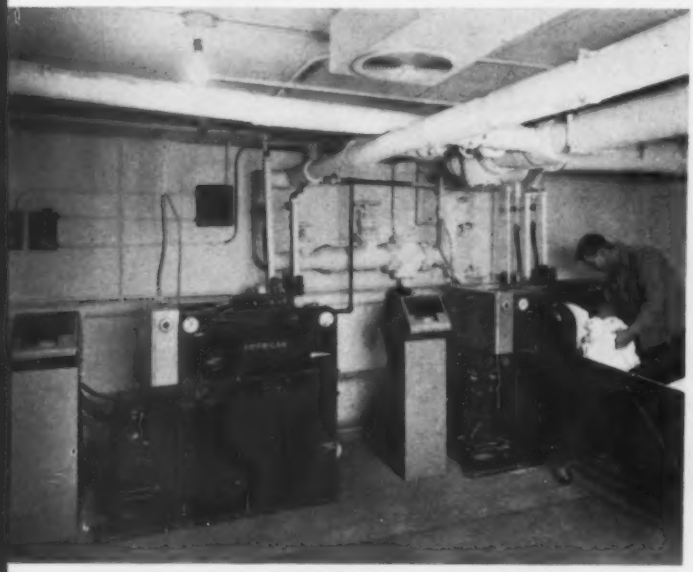

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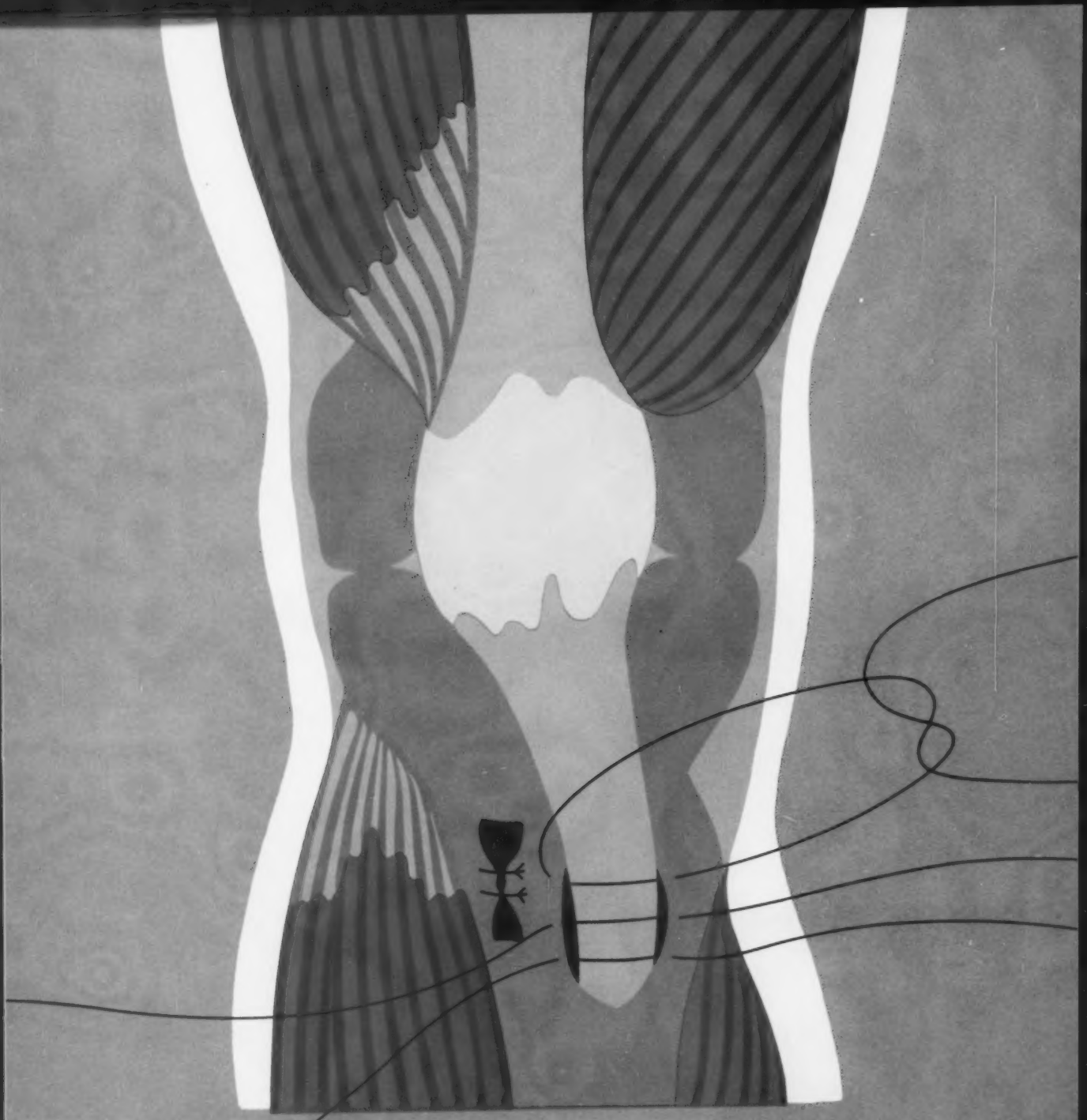

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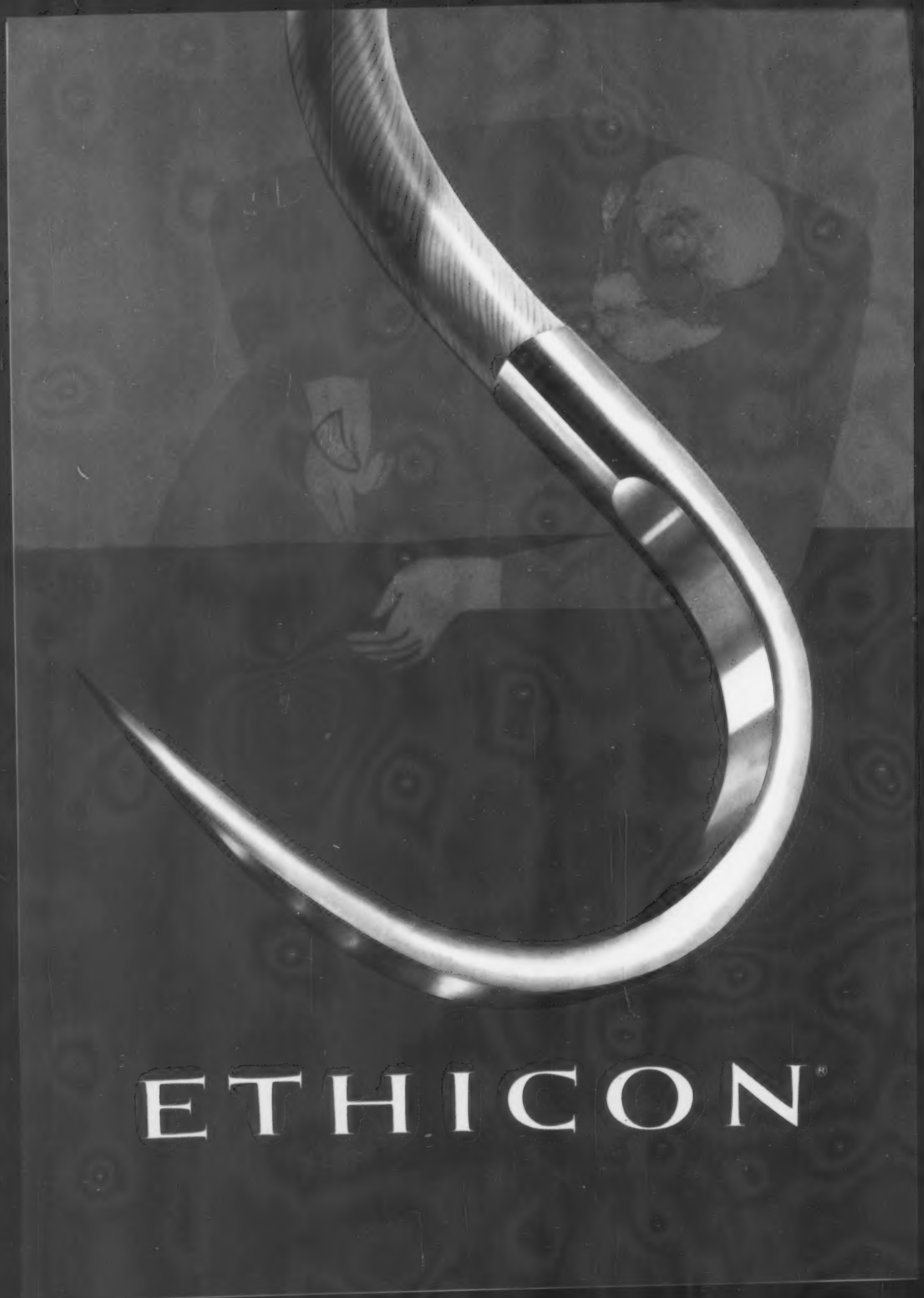
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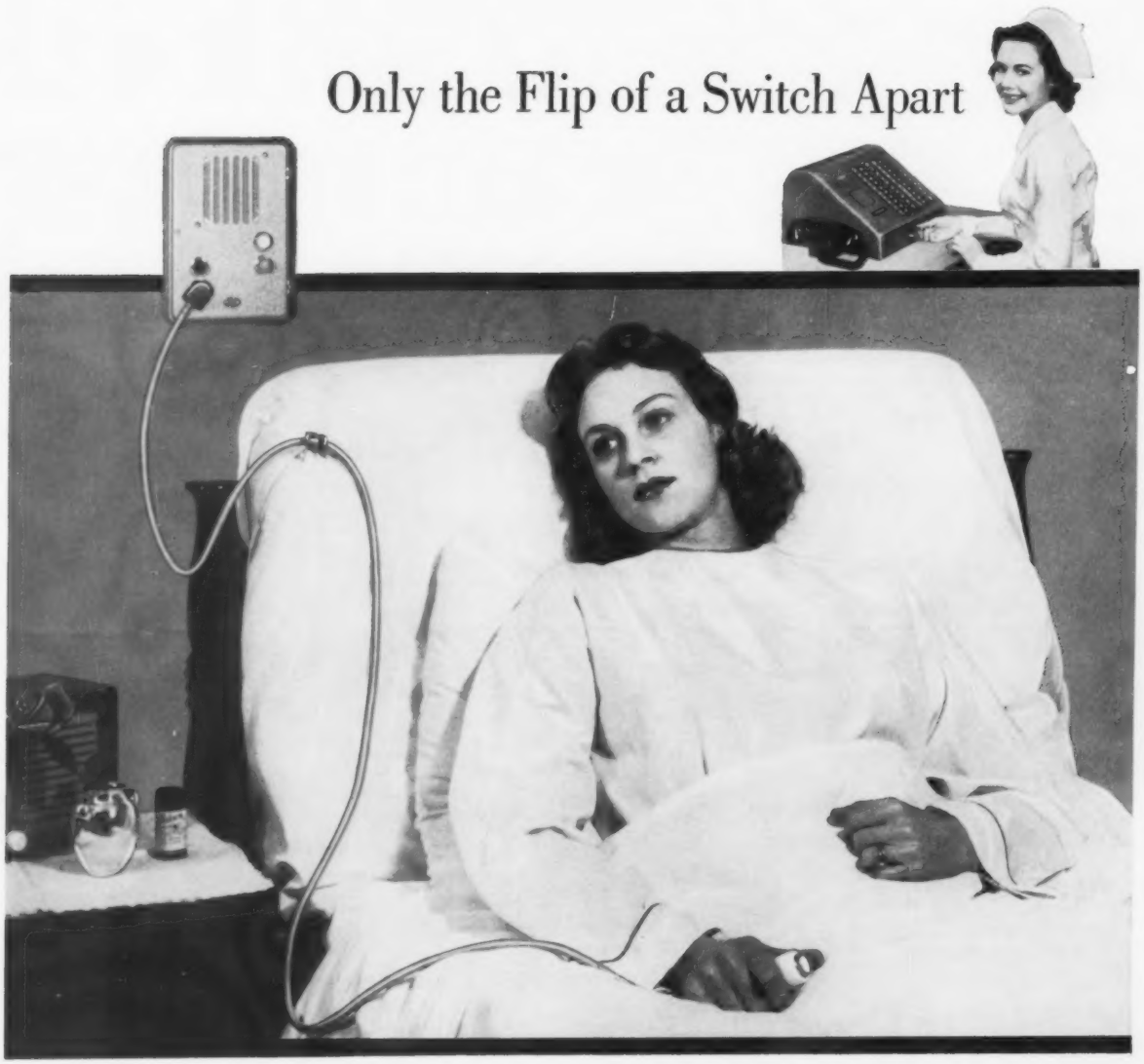

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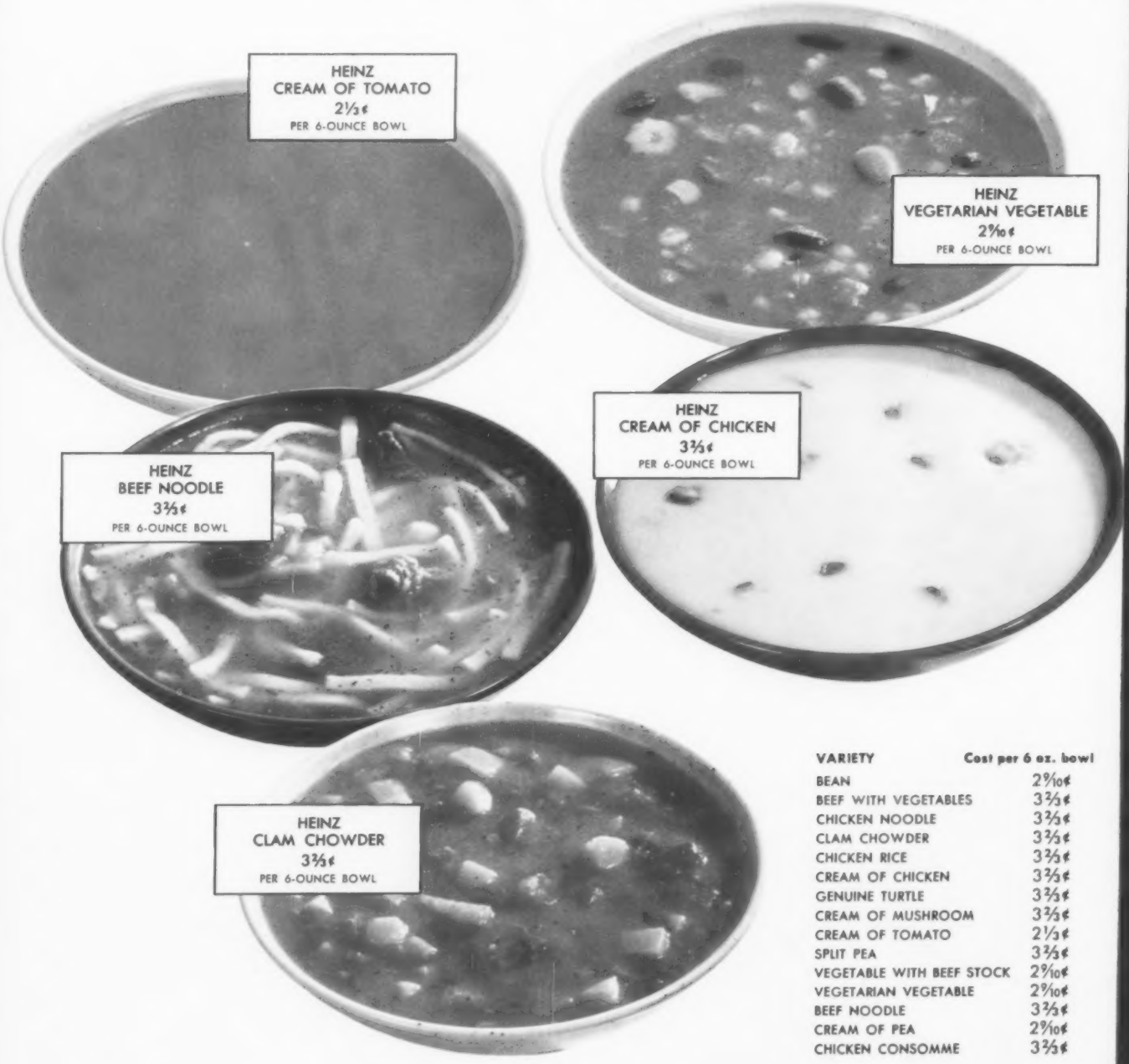

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THEN COMPARE COST. Many kitchens do not know their actual cost on soup because so many of the costs are *hidden*. It's easy to measure the cost of ingredients but how about these hidden costs:

Labor costs . . . Chef's time . . . fuel . . . spoilage and leftovers . . . tied-up cooking equipment

These costs cannot be figured exactly, but they *are* costs and should be considered.

COMPARE AND SEE FOR YOURSELF. Let your own taste and your own costs decide. Fair enough? Fill in the coupon and mail it for your free Chef-Size tin of Heinz Soup *now!*

HEINZ 57 SOUPS

YOU KNOW IT'S GOOD BECAUSE IT'S HEINZ

Heinz 51-oz. Chef-Size Soups are condensed . . . one tin makes two.

FREE CHEF-SIZE TIN OF HEINZ SOUP

H. J. Heinz Co., P. O. Box 57, Dept 28, Pittsburgh 30, Pa.

I'll compare and see for myself. Send me a free Chef-Size tin of Heinz Condensed Soup (makes 102 ounces of soup).

Variety _____
(any soup you choose)

Name _____ Position _____

Affiliation _____

Street _____

City _____ Zone _____ State _____

NEW CONCEPT IN URINE-SUGAR TESTING

CLINISTIX

TRADEMARK

REAGENT STRIPS

specific enzyme test for urine glucose

just dip and read

complete specificity ... unaffected by non-glucose reducing substances ... differentiates glucose from other urine-sugars ... thousands of tests reveal no substance causing a false positive.

extreme sensitivity ... detects glucose concentrations of 0.1% or less.

utmost simplicity and convenience ... a CLINISTIX Reagent Strip moistened with urine turns blue when glucose is present.

qualitative accuracy ... used whenever presence or absence of glucose must be determined rapidly and frequently. CLINISTIX does not attempt to give quantitative results because so many factors in urine influence enzyme reactions.

economy ... CLINISTIX saves time and cuts costs ... each strip is a complete test rapidly performed without reagents and equipment.

available: Packets of 30 CLINISTIX Reagent Strips in cartons of 12—No. 2830.

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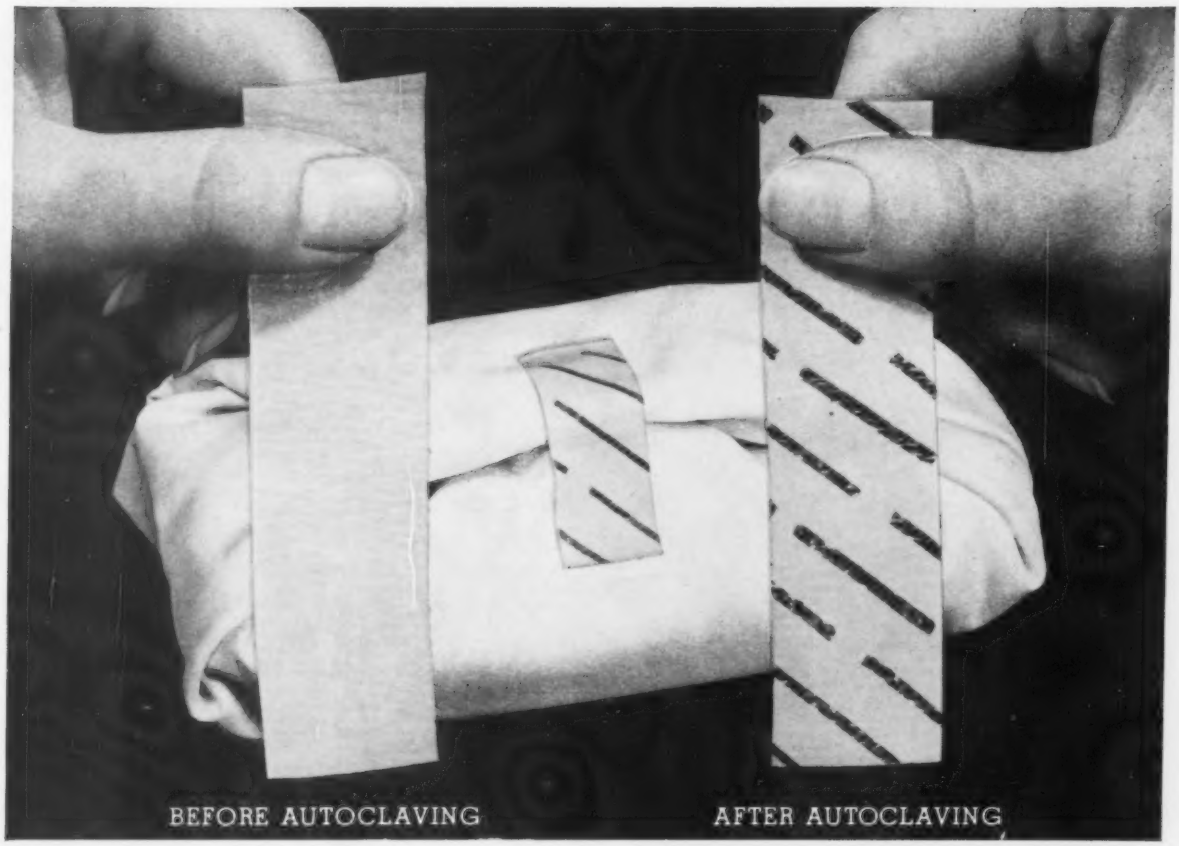

NO GUESSWORK HERE!

"SCOTCH" Hospital Autoclave Tape No. 222 cannot be accidentally activated!

YOU'RE ALWAYS SURE with "SCOTCH" Brand Hospital Autoclave Tape. It tells you at a glance whether a pack has been through the autoclave. The special inks used in this tape *cannot be accidentally activated* by sunlight or radiator heat . . . it takes *high steam temperatures* to bring out the distinctive diagonal markings.

See your supplier right away . . . start enjoying the extra convenience, extra safety of "SCOTCH" Hospital Autoclave Tape No. 222. **• Seals packs firmly in half the time required for pinning, tying, tucking • Holds firmly in high steam temperatures • Leaves no stains or gummy residue • Sticks at a touch, takes pencil or ink markings.**

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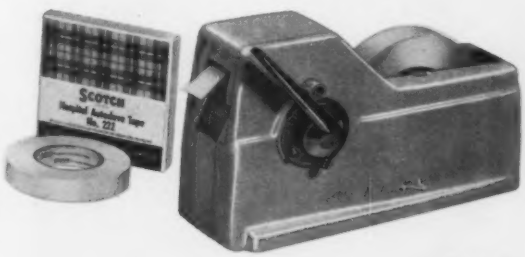
BRAND
HOSPITAL TAPES

• TIME-SAVING • WORK-SAVING • MONEY-SAVING



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cut

patient

accounting

costs

with

BURROUGHS SENSIMATIC

For simplified patient accounting and preparation of Blue Cross reports, you'll find the ideal answer in Burroughs Sensimatic combined with the columnar method of distribution of charges.

With this accounting plan, all charges are automatically indicated under the proper heading on the statement. Then, at the end of the accounting period, totals can be obtained by simply turning a knob and pressing the motor bar. A duplicate copy meets all requirements of Blue Cross. Reimbursement from both Blue Cross and the patient are greatly simplified.

Thanks to the exclusive sensing panel, Sensimatic will handle other jobs by a simple turn of the job selector knob. For a demonstration call our nearest branch office, listed in your telephone directory. Burroughs Corporation, Detroit 32, Michigan.

WHEREVER THERE'S BUSINESS THERE'S

Burroughs B

"BURROUGHS" AND "SENSIMATIC" ARE TRADE-MARKS

Now! 16 Varieties of Kraft PC's for Perfect Portion Control...

A SAVING WITH EVERY SERVING OF THESE PRODUCTS:

PC **Jams and Jellies** (½-oz.)—grape, apple and currant jelly, strawberry jam, orange marmalade, cranberry sauce. **Ketchup** (½-oz.), **Mustard** (⅓-oz.) • **Maple-flavored Syrup** (1½-oz.) • **French Dressing** (½-oz.) • **Mayonnaise** (½-oz.) • **Miracle Whip** Salad Dressing (½-oz.) • **Tartar Sauce** (¾-oz.) • **Toppings** (1-oz.) —caramel, chocolate, strawberry

---

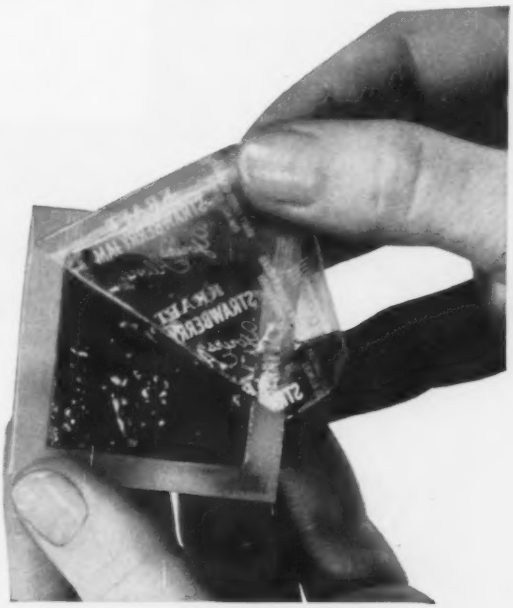
In no other way, at so little cost, can you get all these benefits. It's ideally designed for individual service. Just consider Kraft PC's advantages in *your* food service operation.

Your patrons get nationally known Kraft quality, positive assurance of sanitary service and full measure without favoritism.

Back-of-the-house convenience—Ordering, storing stock and taking inventory can be handled quickly when Kraft PC's are purchased. No more bulk handling of jams, condiments, etc! No time spent portioning by hand—no waste.

Front-of-the-house advantages—Kraft's PC's are easily kept at the points of service. It's only a fraction of a second from PC tray to plate.

Portion control is profit protection. Get both of these benefits. Buy Kraft PC Packs—the most efficient, most sanitary, most satisfactory way to serve these products.



Kraft's quality foods, sealed in plastic for individual use

There are 20 PC's to a tray. All are packed 10 trays to a carton, except syrup, which is 5 trays per carton. PC's are also available in Canada.

KRAFT Foods Company INSTITUTIONAL DIVISION

THE NATION'S TASTE IS YOUR BEST BUYING GUIDE

KRAFT FOODS COMPANY

Perk up patients...and the bright spots in their routine days are often the meals. So serve them on pleasant, appealing Roylprint Paper Place Mats or Roylies Tray Mats... they're light-hearted and cheerful. Colorful paper Roylies or Custom Design Roylprints brighten meals and lighten the staff chores. What's more, Roylprints assure patients of complete sanitation and cleanliness...patients are pleased with the fresh mat for each serving. Roylprints are extra strong, help deaden the noise of chinaware clatter, fit trays perfectly and come in a wide selection of happy colors (one to match your interior design). Or if you wish, you can order Roylprints specially printed with your name and design. Mail the coupon today for more information and samples—no obligation, of course.

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Please send information on Roylprints and Roylies Place Mats—at no obligation to us.

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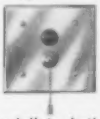
Standard – THE MOST COMPLETE LINE OF HOSPITAL SIGNALLING EQUIPMENT

BEDSIDE STATION with MICROPHONE-SPEAKER

Mounted in one unit, — or microphone speaker can be located apart from calling switch. In ceiling for example.

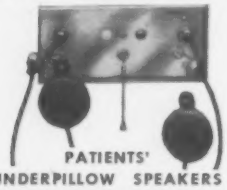


EMERGENCY CALLING STATION

For toilets, bathrooms, or other locations. Lights keep flashing at all calling stations, nurses' station, in corridors, duty and utility rooms until answered in person.

REMOTE TELEPHONE STATION

To answer or make calls from duty rooms or nurses' stations in other sections. Night nurses handle more than one station.



PATIENTS' UNDERPILLOW SPEAKERS

Double Nurse Calling Station with underpillow speakers, radio selector switches, and nurse calling switch. Other combinations available.

CENTRALIZED RADIO

Master Receiver and Control. Has 3 receivers and turntable for recorded programs. Assures clearer, uniform reception; freedom from man-made static. Microphone can be added to distribute chapel services, wired music, etc., originating in hospital. System keeps bedside tables clear for intended uses.

Easy to operate as a dial phone, this nurse is handling a 60 room section (30 and 15 room systems also available). Patient calls can also be answered from corridor, diet kitchen or utility room by lifting receiver and talking. Replacing receiver cancels all lights. Calls to patient's room can be made by dialing from any telephone station in the system.

Royalmatic NURSE SAVER® CALLING SYSTEMS

Audible-Visible Two-Way Type

Calling stations in most common use are illustrated here. Many other combinations available. All Standard Royal equipment is the most "advanced type" on the market. All messages go through the "talk-listen" pattern which increases service to patients; requires fewer personnel; enables less experienced personnel to handle more patient calls; stretches nursing staff; eliminates costly additional equipment, conduits and wiring; permits night nurses to answer from more than one station at a time.

Write for Publication #221

or see phone book for nearest branch offices

Including in Addition to Equipment Illustrated:

PSYCHIATRIC WARD MONITORING SYSTEM

Attendant can monitor patient, ward or room any time from nurses' duty station. Important to nurse who must enter room of disturbed or violent patient.

MATERNITY AND SURGICAL EMERGENCY CALLING SYSTEM

Different colored flashing lamps distinguish calls from surgical rooms from those sent from lying-in, labor or recovery rooms.

COMMON CALL — PRIVATE TALK INTER-COM

Permits paging from any station to all other stations, yet provides 2-way private talk.

AUDIBLE PAGING SYSTEM

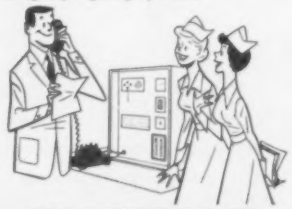
From a single point such as a telephone switchboard to various points at which speakers are located throughout hospital.

RETURN CALL PAGING SYSTEM

Combines audible voice paging to all speakers with private 2-way voice communication from any return call station.

OTHER STANDARD EQUIPMENT FOR HOSPITALS

Doctors' Paging Systems • In And Out Registers • Electric Clock Systems • Fire Alarm Systems • Operating Room Timers Emergency Lighting Systems.



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Let him demonstrate with portable equipment the many advantages of the Royalmatic Nurse Call System.

THE STANDARD ELECTRIC TIME COMPANY

69 Logan Street
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Architects and Engineers:
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◀Here in the "day old" nursery, Nibroc Towels are always within easy reach.

▲New $5 Million, 300-Bed Bishop Clarkson Memorial Hospital, Omaha, Nebraska.

NIBROC® Towels

give us Maximum Sanitation at Lower Cost, says Mr. Hal G. Perrin, Administrator

Bishop Clarkson Memorial Hospital was named 'Modern Hospital of the Year' in 1955—an award based on efficient planning and construction. Part of the planning was the installation of 100 Nibroc Stainless Steel Dispensers for quick-drying Nibroc Towels.

"Well over 2,000 hand washings daily appear to be our use figure," says Mr. Perrin, "and our cost per towel runs about a third of a cent—giving us hygienic protection at a very low cost.

"Nibroc Towels are also used on sterile treatment trays as coverings. We find they are highly absorbent, do not shed fuzz or lint, and are completely without odor, a most important factor in a hospital."

Why not learn for yourself why Nibroc is America's most widely used towel in business, industry and by institutions.

Look in the phone directory under "Paper Towels" or write Dept. NP-2, Boston, for name of nearest Nibroc distributor.

SEE Sweet's Catalog for information about Nibroc Cabinets—wall, floor model and recessed.

BROWN COMPANY, Berlin, New Hampshire
General Sales Office:
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BUSY AS A ClarkeAmatic

Clarke-A-matic Floor Maintainer has two speeds, choice of two sizes, 26" or 30" brush spreads. Electric, propane, or gasoline power.

Clarke Floor Maintainer available in 7 sizes with attachments for 8 different floor jobs.

Clarke Wet-Dry Vacuum Cleaner has extra powerful suction for cleaning everything from floor to ceiling. A size for every job.

—but not nearly as effective at cleaning floors. In fact, there's nothing that even comes close to Clarke-A-matic in cleaning large floor areas in a hurry. And no wonder . . . the Clarke-A-matic self propelled floor maintainer scrubs large areas 10 to 20 times faster than ordinary mopping . . . cleans up to 28,200 sq. ft. per hour. It automatically meters solution to its twin brushes, scrubs, rinses, picks up and dries—all in one easy operation. It handles all floor maintenance quickly and thoroughly . . . slashes costs by cutting cleaning time and labor. Have your Clarke distributor demonstrate it on *your* floors.

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Erythromycin in Treating Pneumonia

A 27-year-old man, a chronic alcoholic, was admitted with a history of an alcoholic spree followed by a cough, greenish sputum and chills and fever.

Physical examination showed a temperature of 104 F. and indicated pneumonia in the right lower lobe. This was confirmed by X-ray. The sputum revealed gram-positive diplococci and blood culture subsequently grew Type VII pneumococci.

The patient was treated with erythromycin, 300 mg. every six hours per os. His temperature dropped to normal by 48 hours and X-ray of the chest revealed considerable clearing by the fourth hospital day. After 10 days hospitalization, the patient was fit for discharge.[1]

First Antibiotics Symposium, we reported the successful treatment with hromycin of *H. influenzae* pneumonia and bacteremia. A second patient with *H. influenzae* pneumonia and bacteremia had a clinical course almost identical to the one previously reported, with cure obtained by treatment with 500 mg. of erythromycin per os every four hours for 14 days.

Of these 132 patients with bacterial pneumonia, 127 (96%) had a good clinical result. One patient with lobar pneumonia had a good initial response but had delayed resolution after treatment.

"Highly Effective in Pneumonia"

In one investigation, 75 adult patients with bacterial pneumonia were treated with erythromycin. In his summary, the clinician reported: "It is concluded that erythromycin is highly effective in the treatment of pneumonia due to gram-positive bacteria."[2]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when you prescribe ERYTHROCIN. Abbott

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Erythrocin®

(Erythromycin, Abbott)

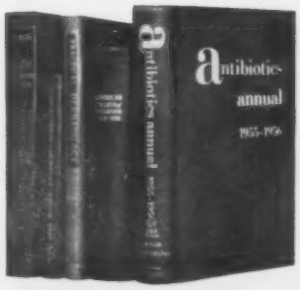
STEARATE

"No Serious Side Effects Occurred"

After a study of 171 patients treated with erythromycin, the investigator wrote: "No serious side effects occurred with prolonged therapy or with doses up to 8 Gm. per day in the severe infections."[1]

Actually, ERYTHROCIN stands on a remarkable record of safety. After four years, there's not a single report of a severe or fatal reaction attributable to erythromycin. In addition, you'll find allergic manifestations rarely occur. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), in bottles of 25 and 100. Abbott

® Filmtab—Film-Sealed tablets, Abbott; pat. applied for.



1. Romansky, M.J., et al., Antibiotics Annual 1955-1956, p. 48,
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M., A.M.A. Archives of Internal Medicine, 1954, p. 556.

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CRA

New...the first and only bedpan washer with a "no-drip" nozzle

Doesn't have to be drained after using

You know what happens if a nurse or nurse's aide forgets to drain the ordinary bedpan washer after she's finished with it. Water drips over the floor and someone has to take time to clean it up.

But not with the Crane bedpan washer. It meets all the latest plumbing sanitary requirements and yet doesn't drip. The secret is a spray nozzle with an exclusive "no-drip" feature. It stops the dripping before it has a chance to start.

For complete information see your Architect or Crane Representative. Find out how Crane specialization can save your hospital time and money.

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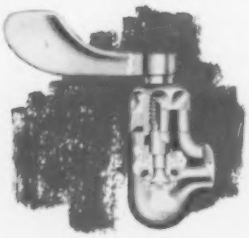
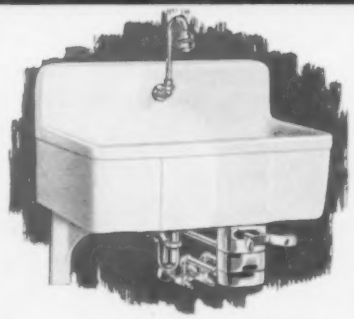
VALVES • FITTINGS • PIPE • PLUMBING • KITCHENS • HEATING • AIR CONDITIONING

Do You Have These Other Crane Exclusives in Your Hospital?



Dial-ese controls on all plumbing fixtures. *Minimize dripping. Close with water pressure. Threads permanently lubricated. Working unit replaced in about 10 seconds.*



Duraclay. *A special vitreous glazed earthenware for large hospital fixtures. Won't crack or craze under thermal shock. Available in white or seven Crane colors.*

Corridor Drinking Fountain. *Fully recessed type leaves hall area clear . . . nothing to clean under. Available with single Wal-Pak or central water chiller for up to sixty installations.*

Chefs prepare food on modern Gas equipment in the kitchen of Roanoke Memorial Hospital

Enough fried chicken for 300 patients in 12 minutes . . . thanks to *GAS*

Modern stainless steel Gas equipment with automatic controls is the key to fast preparation of special and regular diet foods at Roanoke Memorial Hospital, Roanoke, Virginia.

Stainless steel pressure cookers and steam kettles can cook enough fried chicken in 12 minutes to serve 300 patients, after which chicken is browned in a Gas-fired deep fat fryer. Automatically controlled Vulcan Gas equipment—ranges, baking and warming ovens—speed nutritious, tasty food to patients and staff with no interruption in service for changeover to special diets.

For information on how Gas can help you modernize your food service, call your Gas Company's commercial specialist. He'll be glad to discuss with you the economies and outstanding results you get with Gas and modern Gas-fired equipment. *American Gas Association.*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CONTROL . . .
its economies are directly related to your selection of the *right* utensils.
No other manufacturer in the institutional cooking utensil field can match the wide range of sizes, styles, shapes and finishes available to you in . . . *Wear-Ever Aluminum.*
Be sure to insist on this famous trade-mark of quality on the utensils you buy.
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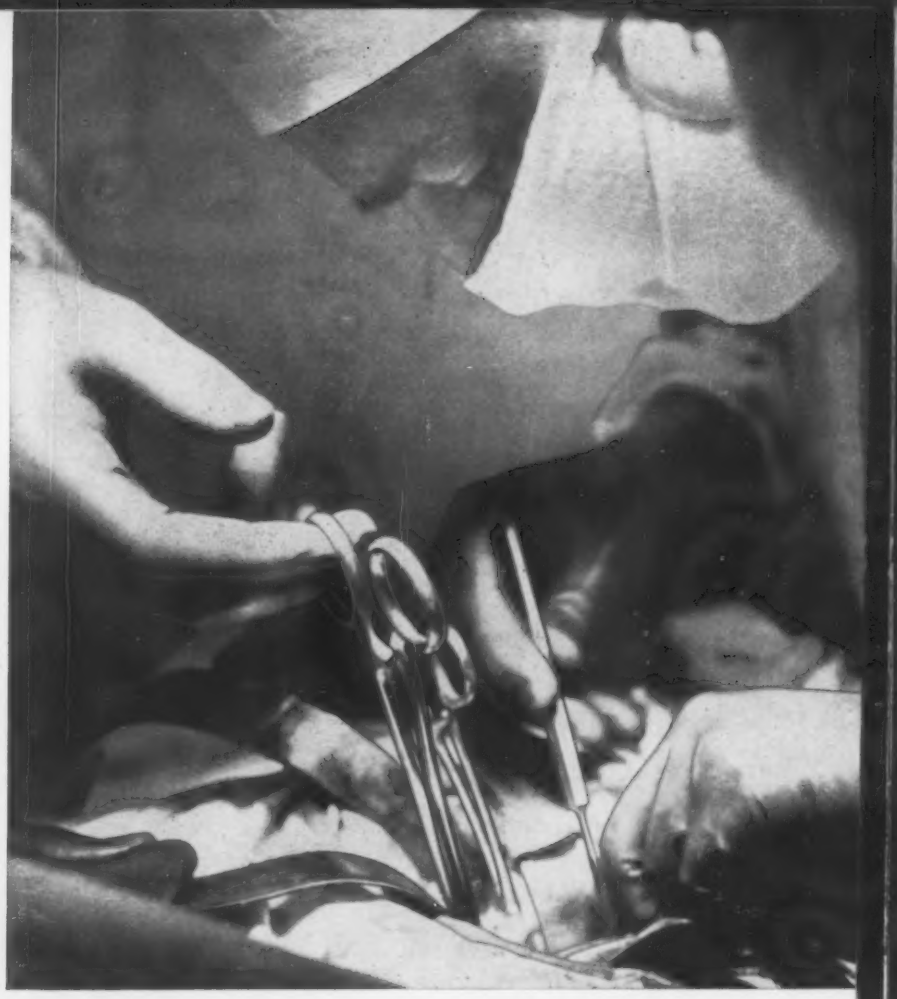
New Catalog! Shows capacities, no. of servings (in ozs.) for most commonly used utensils. Free! Send for your copy today.

don't let *any* hospital hands spread disease



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GERMA-MEDICA®

LIQUID SOAP WITH HEXACHLOROPHENE

Hands do the work in every hospital . . . and hands can carry disease. That's why *all* hospital hands . . . from chief surgeon to typist . . . should be clean and disease-free. Now Germa-Medica* Liquid Surgical Soap with Hexachlorophene makes this standard of cleanliness possible throughout the hospital.

Tests by an independent research laboratory prove a daily 3-minute wash using Germa-Medica*, diluted as much as 4:1, reduces bacteria in the area cleansed well below safe levels, produces a bacteriostatic condition that lasts for many hours. Yet highly-concentrated Germa-Medica* *costs only 1/5c a wash.* A fine soap made with imported olive oil and an effective emollient, Germa-Medica* with Hexachlorophene does not leave hands irritated or sensitized.

Help control the spread of communicable disease by using Germa-Medica* for hand washing everywhere in your hospital. Write today for a free sample. Test the remarkable germicidal action of Germa-Medica* Liquid Soap with hexachlorophene.

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HUNTINGTON LABORATORIES, INC.
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☐ Please send free sample of Germa-Medica* with Hexachlorophene and test result booklet.

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*Reg. U.S. Pat. Office

Natural Fog—for respiratory tract disorders

a supersaturated humidity, a prescribed temperature, and still a COOL, DRY patient

One doctor called it "air conditioned" humidification. Air conditioned humidification or "Natural Fog," the indisputable fact remains that the Melco "Natural Fog" Generator is producing in an entire hospital room the therapeutic humidification that physicians have long desired.

The Melco "Natural Fog" Generator DOES provide a supersaturated patient atmosphere. It DOES enable the physician to prescribe temperature between 68° and 85°F. It DOES supply moisture in therapeutical size. It DOES all of this without precipitation.

The Melco "Natural Fog" Generator increases the amount of moisture available for therapeutic purposes. And produces supersaturated humidity at a temperature that is comfortable to the patient. This patient comfort, according to many physicians, contributes significantly to continuous and uninterrupted high humidity therapy. From a physiological point of view, a lower metabolism is maintained than in the high temperature of the old fashioned steam room.

These then establish the clinical utility of "Natural Fog" . . . "conditioned humidification" . . . as a therapeutic tool.

Any of the above statements can be verified by the hospitals which have installed a Melco "Natural Fog" Generator. A list will gladly be forwarded on request.

IMPORTANT

Without obligation, we shall send you complete information and prices, medical reprints and a list of hospitals using the Melco "Natural Fog" Generator. Write Dept. 101. Medical Equipment Division.

Melco

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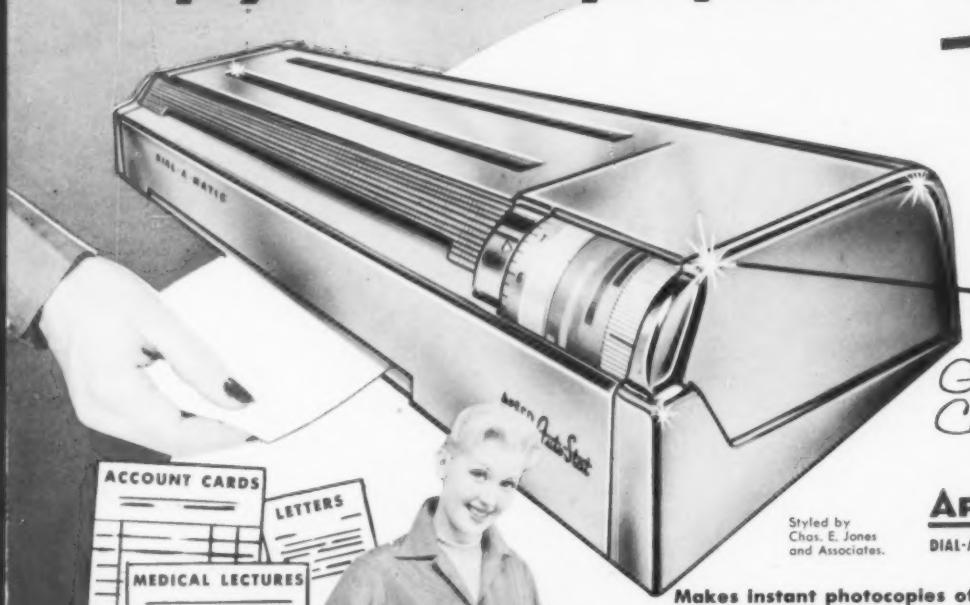

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Makes instant photocopies of anything written, printed, typed, drawn, or photographed—right in your own office.

Hospitals throughout the United States have accepted Apeco Auto-Stat as standard equipment to handle their many applications for copying. It makes exact photo copies of anything in seconds. With the new all-electric 1957 Apeco Dial-A-Matic Auto-Stat you can get clear, bright, sharp black on white copies and it's so easy. The magic touch dial control assures a perfect copy every time. Styled in polished, gleaming, stainless steel—the Apeco Auto-Stat is handsome, light weight, and compact. It copies any original up to 15" wide—any length or color on opaque or transparent paper—printed on one or both sides. It offers hundreds of time and money saving uses for every hospital and is priced well within the budget of even the smallest institution.

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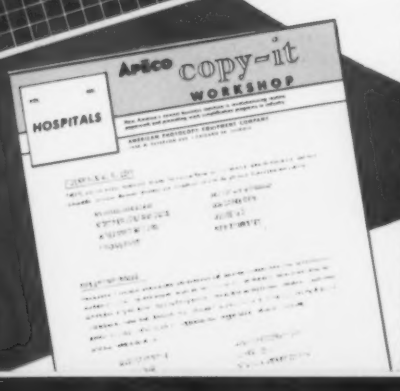
Plus a special report on how Hospitals use Apeco Auto-Stat Copying.



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HOSPITALS

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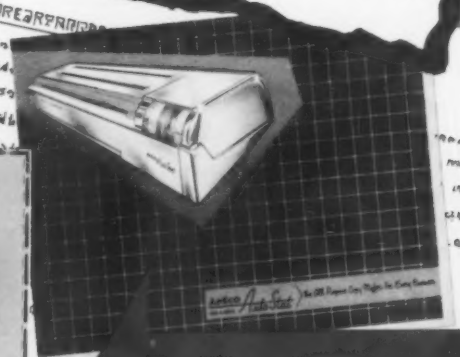

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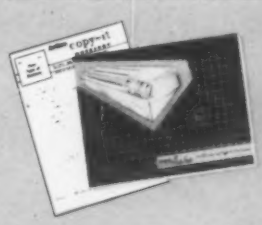

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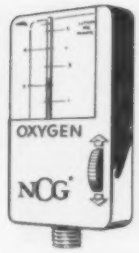

FIRST flowmeter made of nylon with clear gauge panels of Lucite* . . . has all the strength a flowmeter should have plus new beauty no flowmeter has ever had before. In two models, 0 to 15 liters for general use and first 0 to 5 liters model for use exclusively in nurseries. Lightweight, compact, easy to read and extremely accurate. Here is a rugged, safe and easy to use flowmeter for all piped oxygen systems to accurately regulate flow through all types of equipment. In accelerated test, this flowmeter was used for equivalent of a decade.

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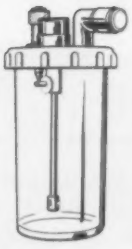

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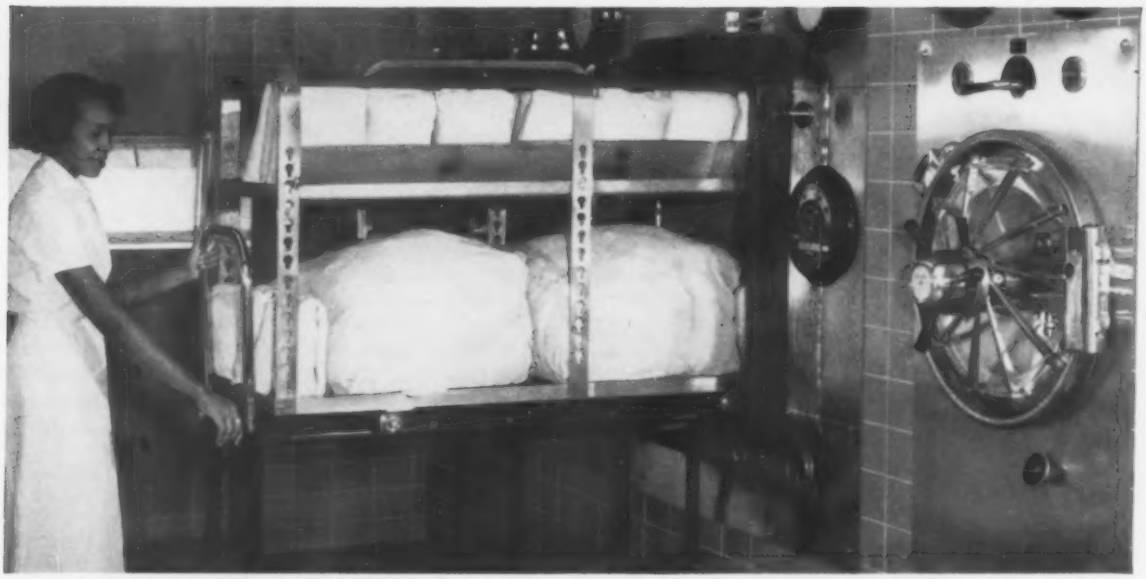

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At Northside Division, Wilmot Castle sterilizers provide the needed efficiency. Large-order sterilization is serviced by Central Supply (shown above) with an all-Monel Cylindrical Dressing unit and two Nickel-clad Rectangular units.

Here, large bulk material rolls in and out easily and quickly on loading cars and rollers made of long-lasting Monel* nickel-copper alloy. Thermatic Controls establish the proper cycles while Recording Thermometers check performance.

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photo technic: *light-tracings of hands to which bulbs are attached.*

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SMALL HOSPITAL QUESTIONS

Don't Restrict Auxiliary

Question: We are in the process of organizing a women's auxiliary for the hospital for the first time, and some of the women who have taken a leading part in getting the movement started are insisting that membership should be restricted to wives of doctors on the medical staff. Is this customary?—D.M.S., S.D.

ANSWER: No, and there doesn't seem to be any logical argument in support of any such restriction on membership. The whole idea of having an auxiliary is to organize and utilize in every possible way the considerable reservoir of good will toward the hospital that exists in the community. Why restrict it? Even in the smallest hospital communities, having only a dozen or so doctors, there may be upward of 100 women who are eager to volunteer their time and service for the benefit of the hospital and its patients. There should be only one requirement for auxiliary membership —willingness to serve!

Selective Menus Not Costly

Question: I would like to see our patients given selective menus, at least for one meal a day, but our food service director says this would be costly and is done only in large, high priced hospitals. Is this true?—M.R.P., N.C.

ANSWER: No; 25 per cent of hospitals in the 100 bed size group are offering selective menus for all patients, according to one recent survey. Food service authorities, for the most part, say this can be done without any substantial addition to food cost.

Room for Meditation

Question: We are contemplating an addition to our facilities, and I have suggested the plans should include space for a "meditation room" for retirement and prayer by families of critically ill patients. I feel sure families, and the community generally, would appreciate this, and I have been told this is the case by other administrators, but some of our doctors and board members regard such a room as an unnecessary "frill." What is the customary practice?—N.W.W., Ore.

ANSWER: Only a few hospitals provide such a room—probably not more than 10 per cent of hospitals having 100 beds or less, and most of these, probably, would be hospitals having some religious affiliation. Religious feeling and practice in your community should be the governing factor in determining whether a meditation room would be desirable. Possibly it would be worth while to conduct a survey among a careful sampling of patients, former patients and their families to determine whether or not this would be an advisable move.

Pharmacy Is an Economy

Question: We do not have our own pharmacy in our 35 bed hospital. Instead, we have always purchased drugs as needed from a retail pharmacy in our community, under an arrangement with the pharmacist which permits us to save money on certain items, compared to the established retail price. We are now considering the advisability of establishing our own pharmacy, and opinion is divided among our doctors and board members as to the advisability of doing so. What is the prevailing practice among hospitals in our size group?—R.F.C., Ill.

ANSWER: Recent studies conducted by the U.S. Public Health Service show that 25 per cent of hospitals in the 25 bed class operate their own pharmacies; this figure rises to 40 per cent among 50 bed hospitals, and 65 per cent among 100 bed hospitals. While it can be conclusively demonstrated in most cases that operation of a pharmacy is an economy in the hospital — through savings on purchases, better inventory and stock control, and improved service to doctors and their patients, there are several alternatives that may be considered. One is the employment of a part-time pharmacist who will combine operation of the hospital pharmacy with other duties inside the hospital. Another is the employment of a part-time pharmacist who has other duties outside the hospital—possibly one who serves as pharmacist to several hospitals in the same general area.

Another method that has been used successfully in a number of hospitals is the employment of a pharmacy consultant who comes to the hospital only occasionally but is available for consultation on pharmacy problems by telephone and correspondence. Finally, you may wish to consider another type of arrangement with the local retail pharmacist, under which he is paid a specific fee for establishing and operating a pharmacy department in the hospital on a part-time basis, instead of selling drugs to the hospital at a profit. For further details about these arrangements, see the article by Grover C. Bowles Jr., chief pharmacist of Baptist Memorial Hospital, Memphis, Tenn,. on page 106 of this issue.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif., Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

For Up-to-Date Dishwashing

Question: I would like to invest in a mechanical dishwasher and believe we can save money for the hospital this way in the long run. One of our board members (who is also treasurer of the hospital) doubts this would be an improvement. Can you supply figures to prove my point?—D.W.T., Mo.

ANSWER: Well, the fact that 80 per cent of hospitals have mechanical centralized dishwashing facilities may help you persuade this board member that he is behind the times.

Alcoholics Accepted

Question: We have recently seen publicity, and I believe a resolution from the American Medical Association, urging community hospitals to accept and treat alcoholics. How many hospitals do this, and how is the service organized?—A.A., Tenn.

ANSWER: About one-fourth of community hospitals queried in a recent survey said that they accepted alcoholics for treatment. The service must be organized by the medical staff. The American Medical Association recently did approve a resolution urging hospitals to organize such a service, and has made recommendations concerning the nature and extent of the service to be rendered.

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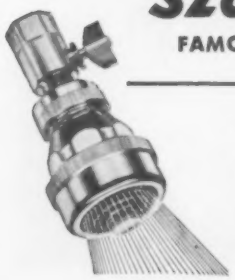

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PROSPECTS FOR HOSPITALS

With the new Congress digging in to its work, and the Eisenhower crowd taking a firmer grip on the administration, hospital news is sprouting all over Washington.

The President's budget, now in the hands of Congress, would give about the same amount of money for Hill-Burton hospital construction grants.

New bills in Congress would greatly alter the hospital picture—they're startling, some of them, but not many will be passed.

Financed largely by federal money, American Hospital Association is about to embark on one of the largest research programs ever undertaken by any nongovernment group.

A dynamic figure, long experienced in hospital work, is the new top medical adviser to Secretary Folsom, responsible for relations with the profession and guiding the shape of H.E.W. legislation.

There is a feeling in the air that, even with more tax money going for foreign aid and military preparations, there will be plenty left to spread around in the medical-hospital fields.

Now, the most important details:

HILL-BURTON. The cold figures in the official U.S. budget make it appear that the Hill-Burton hospital construction program has been cut back over $4 million in the President's recommendations. That is not actually the case, because money allowed for salaries and expenses would just about bring the total up to what it is for the current fiscal year. Here are the statistics:

Two years ago Congress voted a total of $111 million, $90 million for the old program and $21 million for the new (nursing homes, diagnostic-treatment centers, rehabilitation centers, and institutions for the chronically ill).

Last Congress upped the total to $125 million, with $102 million for the old program and again $21 million for the new.

The President now is recommending a total of $121 million, with $90 million for the old program and $30 million for the new. Administrative allowances, not shown in the new figures, would bring the total up close to $125 million. At any rate, the amount is expected to see the program through another good year.

VETERANS ADMINISTRATION. The most startling development here is a bill by Chairman Olin Teague (D.-Tex.) of the House veterans affairs committee that would put teeth into the now familiar form 10-P-10. This is a committee bill, based on extensive work by the committee staff, and it has a fine chance of enactment, unless fought too bitterly by veterans organizations.

This form requires a veteran with a nonservice-connected condition who applies for hospitalization to give a fairly complete financial statement. Then he answers the key question as to whether he can or cannot afford to pay for private treatment.

The Teague bill would make two important changes. It would make the 10-P-10 a legal requirement; now it is merely a regulation that could be dropped by the V.A. at any time. And, second, it requires the V.A. official handling the application to (a) explain to the veteran the criminal punishments for making a false statement, and (b) if the hospitalization is to be for less than 30 days, estimate what the cost would be in a private hospital and so inform the veteran.

While this bill admittedly would be effective, it still avoids tampering with the right of the veteran, regardless of his finances, to declare that he "cannot afford" to pay for the treatment. Under the law, V.A. or no other agency may challenge the veteran's answer. But the Teague bill would make abuses less likely.

On the appropriations side, the Eisenhower budget calls for $50 million instead of this year's $52 million for V.A.'s hospital and domiciliary services, which include construction, replacement of buildings, purchase of sites, and conversion and modernization.

There is an increase in the money asked for inpatient care, from $663 million to $702 million. This is for actually running the hospitals and providing professional service.

Money for V.A. outpatient care—hometown care mostly—would be cut from about $83 million to $79 million, but the reduction is mostly explained by a falling off in the dental care phase.

As in other recent years, the bulk of V.A.'s appropriations is based on an average patient load, set at 140,800 for next fiscal year. If the patient load falls below this, V.A. gets correspondingly less of the $663 million scheduled for inpatient care.

PUBLIC HEALTH HOSPITALS. The budget asks an increase of almost 50 per cent in money for Public Health Service to run its 16 hospitals and outpatient facilities. Merchant seamen and coastguardmen and their dependents make up the bulk of patients, but these hospitals also handle Bureau of Employee Compensation cases, some military dependents, foreign seamen, leprosy patients, and narcotic addicts. The hospitals would get more than $44 million next year, in comparison with this year's $29 million.

NEW LEGISLATION

In the opening rush of Congress, most of the old favorite bills in the hospital field were reintroduced, but along with them came a number of new ones. One of the more interesting is a proposal to allow nonprofit hospitals to get long-term, low-interest loans from the government, advanced for the benefit of some institutions that disapprove federal grants yet are not eligible for loans from the Small Business Corporation, which are restricted to profit making organizations.

Problems of the aging—involving hospitals and nursing homes—came in for a great deal of attention. Two separate bills call for commissions to study, investigate and hold hearings on all problems of the aging, but with emphasis on medical. Another suggestion is to set up a bureau in the

Department of Health, Education and Welfare to handle these problems at the national level.

One House bill would authorize open-end matching federal grants to states to maintain and increase enrollment in schools of nursing and to provide nursing scholarships. The program would be under the Surgeon General, who would give each state not less than $200,000 for these purposes.

A Democrat got in first with a bill similar to one to be introduced by the Administration to waive anti-monopoly laws and permit small insurance companies to pool some of their assets for experimentation in expansion of medical and hospital insurance.

Another administrative proposal, not acted on by Congress last session, would authorize $15 million in 50-50 matching grants to start out a program of help to medical, dental and osteopathy schools for building and equipping teaching facilities. Some Democrats want to go farther and offer money to meet ordinary operating expenses, such as salaries.

For doctors and other self-employed who have pleaded for tax relief, Reps. Eugene Keogh (D.-N.Y.) and Thomas A. Jenkins (R.-Ohio) have introduced new bills that may escape the label of "rich man's legislation." They would allow the taxpayer to set aside limited amounts of his income for pension purposes, paying the deferred income tax only when he receives the money in retirement payments.

A.H.A. RESEARCH EXPANDED

Largely on the strength of a $575,000 grant from the U. S. Heart Institute, the American Hospital Association is greatly expanding its research program. Specifically, the project is a nationwide evaluation of the effectiveness of drugs in treating heart disease.

Alan E. Treloar, head of research for A.H.A., will direct the study, which will enlist an advisory board of medical research workers and clinicians who will be responsible for establishing guiding principles and making broad policy decisions.

A.H.A. plans to locate the study's central staff at the association's headquarters in Chicago. A clinician and a biostatistician will coordinate the activities, and a technical committee, composed of representatives of each of the collaborating medical research teams, will maintain communication among the teams involved.

But A.H.A. is not stopping there. It is hopeful that the U. S. will approve a matching grant of about $220,000 to help construct and equip a sixth floor in the new A.H.A. headquarters building now going up in Chicago. The agency making the decision is the advisory council to the lab facilities program, established last year by Congress to make matching grants for medical research construction.

At its December meeting the council passed up the grant, but did not actually reject it. It is understood the council thought a project of this nature might not exactly fit in with the intent of Congress. However, the application is not dead. In February a council committee will visit the site in Chicago, and the council will act on its recommendations early in the spring.

A.H.A. already is at work on another project, also underwritten by a substantial grant of Hill-Burton research money. This is a study of hospital architecture. At the same time the association is using a $60,000 Kellogg foundation grant for another study.

Thus the A.H.A. already has at its disposal about three-quarters of a million dollars in federal money for various research projects. If the $218,937 request is approved, along with a lesser application, the association will have well over a million dollars in U.S. money to use for research in hospital fields.

FOLSOM'S NEW MEDICAL ADVISER

New top-level medical man in policy councils of the Department of Health, Education, and Welfare is Dr. Aims Chamberlain McGuinness, titled special assistant to the secretary (see *p.* 146). He succeeds Dr. Lowell T. Coggeshall, who has returned to the University of Chicago as dean of the division of biological sciences.

The job is not a simple one, nor merely an honor. Dr. McGuinness will be expected to keep good relations between Secretary Folsom on the one hand and the entire medical profession on the other—physicians, hospital people, nurses, dentists, medical schools. He will also be a sounding board for the secretary's legislative ideas, and will be expected to circulate on Capitol Hill and put out any little fires that might endanger H.E.W.'s various medical programs. Old acquaintances say he was made for the job, and his record indicates he is coming into it prepared for most of the problems.

Dr. McGuinness is tall and rangy, bald headed but not gray. In action he's dynamic, but generally he doesn't leave that impression. He is not much given to red tape, insisting on getting things done without great concern over just how they are done. Whatever his qualifications, they will be on public display shortly when Mr. Folsom starts pressing for the Eisenhower health program.

The new Folsom aide has an impressive reputation as a pediatrician, and several times has been in private practice, but he is noted mostly as a skilled medical administrator.

Dr. McGuinness received his A.B. from Princeton in 1927 and his M.D. from Columbia in 1931. After practicing in Philadelphia he joined the University of Pennsylvania medical faculty in 1934. He was director of Children's Hospital in Philadelphia from 1948 to 1951, and dean of the university's graduate school of medicine from 1951 to 1954.

In 1954 he took over as clinical director of the United Mine Workers' hospital chain, and after seeing through most of the construction and staffing problems he returned to private practice. Among other army duties in World War II he was assistant administrator for the army epidemiological board.

NOTES

In most health programs, the Eisenhower budget takes a moderate approach as in Hill-Burton. In consequence the total increase for all of Public Health Service is held to less than 7 per cent.

Some exceptions are Food and Drug Administration, which gets a substantial increase; the Office of Vocational Rehabilitation, up $7 million; air and water pollution control programs, up about 50 per cent each, and work on chronic disease and health of the aged, up about 400 per cent to $2.7 million.

The budget was kept tight by holding down on recommendations for the institutes of health, whose funds were more than doubled by the last Congress. While moderate increases were recommended for most institutes, the cancer program actually was cut more than a million dollars, to about $47 million.

As soon as the budget was released, Democratic liberals decided they would make a fight for increasing many of the research funds.

The Modern Hospital
FEBRUARY 1957

LOOKING AROUND

Ends Before Means

THE two businessmen had been exchanging hospital experiences, and, as men everywhere like to do, they fell to playing that popular game, If I Were Running the Hospital.

"The first thing I'd do," said the Practical Man, "would be to analyze the methods. What that hospital needs is some efficiency studies. Especially the nurses!

"Yes, sir, I'd get some time and motion studies of those nurses going right away," the Practical Man continued. "The money you could save! Why, I watched nurses change the sheets, and I studied the way they gave me my bath, and took temperatures, and all. You wouldn't believe the wasted steps, the unnecessary movements, the inefficient use of supplies and materials!

"And the maids who served the trays! They'd push that heavy cart up the corridor and stop outside the door, then leave the cart to open the door, then back to the cart to pick up the tray, then bring the tray in to put it on the table, then back to the cart to get something they forgot, then back to adjust the table, and so on. What a field day for a methods engineer! Yes, sir, efficiency. That's the first thing I'd do. Wouldn't you start with some methods studies?"

"Well, no, I wouldn't start with methods," said the Philosopher. "First of all, I'd examine the *reasons* things are done."

"Well, but, in this case, the reasons are obvious," said the Practical Man. "I mean, these people are all sick, and they have to have what the doctors and nurses say. But, of course, somebody has to make the beds, and give the baths, and take the temperatures, and serve the meals."

"Why?" asked the Philosopher. "Who says they do? That's what I'd find out. Why do you have to change the sheets every day, for every patient? Or give baths? Most of the patients on my floor could bathe themselves, if they wanted to, or go without. If we studied ends instead of means, we might find patients all over the hospital who could take care of themselves, if they were allowed to.

"And all those temperature and pulse recordings! Who cares? There may be reasons for taking temperatures and pulses for some patients, always, but I'd certainly want to know the reasons it has to be done for everybody, all day long.

"The same with meals. There were 30 or 40 patients on my floor, I should say, and, judging from the traffic in the corridors, about half of them were on their feet—part of the time, at least. Why couldn't they go down in the elevator and eat in the cafeteria? Again, I'd look at the reasons."

"Oh, you'd never get anywhere asking questions like that in a hospital!" the Practical Man said as they parted. He walked down a long row of desks. "Efficiency is what's needed there, all right," he said to himself. "Like I always say, efficiency." He came to the last desk in the row, and sat down.

The Philosopher turned the other way. "Reasons," he murmured to himself. "Like I always say, consider the end before the means." He came to a door marked "President," and went inside.

Citizens First

NOT long ago, we sat with a group of hospital administrators who were talking about their community responsibilities outside the hospital. Someone mentioned the necessity for avoiding involvement in partisan political issues, and the group agreed this was essential.

"No matter how careful you are to point out that you're acting as an individual, and not for the hospital," said one man, "the fact is that in the community you are always identified with the hospital, and you can't get mixed up in politics without hurting the hospital."

"That's right," another said sententiously, "the hospital takes care of Democrats and Republicans alike, and must always be nonpartisan!"

We think this is rubbish, and we said so. The obvious fact that a community hospital is nonpartisan and cares for Democrats and Republicans alike has nothing to do with the political views and responsibilities of the administrator; it would make just as much sense to argue that the administrator mustn't go to his own church, because the hospital cares for patients of all faiths!

In our society, every man is a citizen before he is a hospital administrator, or an insurance salesman, or a bricklayer, or a doctor, and every citizen has a political responsibility. In most cases the citizen can discharge his political responsibilities by voting his convictions privately, as the law allows him to do. But there may be occasions, always, when the citizen's convictions demand that he stand up and be

counted on one side or the other, or take part in a campaign, or get "mixed up in politics" on some local issue that may have partisan implications.

As long as his convictions are honest and his conduct is reasonable, there should be nothing to restrain any citizen from taking part in political debates. If this is not so, and if the hospital administrator may not properly take part in politics, or another man may not, or another, then this concept we have struggled to improve ever since it first appeared in the Age of Pericles—the concept that every citizen must assume his share of responsibility for the political organization of society—is a false concept, and Madison and Jefferson were fools, along with Milton and Aquinas and Solon.

Of course, the hospital administrator who is a Democrat may prefer to keep his convictions to himself lest his Republican board members think he is out of his mind. This may be a sensible thing to do, but let us not pretend he is acting in the interest of hospital patients.

Pressure Won't Produce

DURING the last month or two, we have read or heard statements by doctors in Massachusetts, Illinois and California claiming they were subjected to heavy pressure to make large donations to their hospital fund-raising campaigns. In effect, the doctors charged, they were threatened with loss of hospital privileges if they didn't come across.

We doubt that this has happened in more than a few, widely scattered cases. Uniformly, the men who manage hospital fund-raising campaigns have told us they avoid pressure like the plague, for the most practical of reasons: It doesn't work.

"A hospital campaign can't possibly succeed without the cooperation of the medical staff, because the whole community usually looks to the doctors for leadership and advice in matters affecting the hospital," one campaign director told us. "Without the doctors' support, we'd be lost, and any suggestion of high pressure tactics would turn the doctors against the campaign right away. So it simply isn't done."

Instead, in successful campaigns, the hospital staff is usually asked to organize itself, with a committee of doctors establishing quotas by one or another of several tested methods, and with only doctors asking doctors for money. Again the reason this is done is that it works. Over the nation, doctors have contributed from 15 to 20 per cent of the totals given in hospital campaigns, fund-raising counsel report. "With high pressure, you wouldn't make a nickel," our man said.

Unquestionably, there have been instances in which ill-advised hospital boards or overenthusiastic campaign directors have tried threats and pressure tactics, as a few doctors have charged. Obviously, however, the practice is not widespread. It could be that in some cases, at least, the charge of high pressure fund raising is a smoke screen laid down by men whose privileges are shaky for other reasons.

Lost Ground

THE public attitude toward hospitals, we have always insisted, is shaped at the bedside, and not in the administrator's office, or at the cashier's desk, or by little pamphlets telling how many people work in the kitchen and how much it costs to buy an x-ray machine.

The truth of our contention was never demonstrated so devastatingly as it was the other evening when a friend of ours took her aging mother to a hospital near here for treatment of a leg with severely deteriorated arterial circulation. The hospital is a good one, presumably—at any rate, it has an active public relations department turning out a lively barrage of attractive pamphlets and bulletins and keeping the hospital on good terms with local city desks.

Well, a few minutes after our friend got her mother to the hospital, one of the nurses came into her room, marched up to the bed and declared loudly, "I suppose you're the patient with the gangrenous foot!"—using a word that her doctors and her family had carefully avoided uttering during all the painful preceding weeks.

As if that weren't bad enough, our friend related sadly, the next morning a resident physician came in with a medical visitor and remarked brightly to the visitor, as the old lady lay there suffering, "You're *lucky* to see two of these acute cases on the same day!"

Probably there isn't anything administrators can do to prevent this kind of episode from happening—if they care, and most of them do. There is no way to guarantee that the doctors and nurses in a hospital will always remember that patients and their families may be frightened or offended by carelessness or callousness. Systematic reminders to the staff and the nurses may help reduce the incidence of these lapses, but the best administrative and public relations technics can never regain the ground that may be lost by a moment's thoughtlessness at the bedside.

Dangerous Nonsense

IN AN article on "Creative Retirement" that appeared recently in the *New York Times Magazine*, Clarence B. Randall, who retired not long ago as president of the Inland Steel Company but has managed to stay in business as an adviser to President Eisenhower on foreign trade, suggested that "the world needs the part-time service of men of wisdom and experience."

Nobody in his right mind would quarrel with Mr. Randall on that point, but when he then added that "hospitals need administrators . . . such organizations could not possibly afford to pay for the quality of ability and devotion which the happy retired man is willing to give," he was writing dangerous nonsense. The idea that anybody who can add and subtract can run a hospital in his spare time was discarded at about the time doctors stopped using leeches, and it is shocking that a man of Mr. Randall's standing in the business community could be so unaware of the nature and complexity of hospital administration today as to permit such an idiotic suggestion. What would Mr. Randall think if it were proposed that a retired hospital administrator could step into his shoes as president of Inland Steel?

As Aristotle observed, the work of the harp player is to play upon the harp. It takes more than the miscellaneous ability and devotion of a happy retired man to make a hospital administrator. Mr. Randall, you should live so long!

Why Laboratory Standards Are Substandard

Budget-conscious administrators, the shortage of technologists, high turnover, low—or no—curriculum standards in "quickie" laboratory schools are some of the things that put laboratory standards, as well as patients' lives, in a dangerous position

PENNY-PINCHING by hospital administrators, combined with an acute shortage of medical technologists, is making a shambles of hospital laboratory standards, if not actually imperiling hospital patients, and encouraging "quickie" laboratory schools and their graduates, to the detriment of qualified medical technologists, in the opinion of many leading pathologists and medical technologists themselves.

These conditions exist at a time when advancing technology has created an unprecedented demand for medical technologists with even higher standards of training and performance than have been required in the past.

To measure the problem and determine means for improving hospital laboratory standards, a Medical Technology Study Committee has been created, with representation from the American Society of Clinical Pathologists and the American Society of Medical Technologists. Under a grant from the U.S. Public Health Service, the study committee will develop a plan for surveying present needs in medical technology training. There is need for real exploration of this area of professional education that has been subjected to such increasing pressures during the past decade, it is plain from the facts and opinions that have been reported recently to The MODERN HOSPITAL.

Here are some of the problems and criticisms of hospital practice and laboratory school standards that have come to light:

1. There is a desperate shortage of properly trained medical technologists; authorities estimate that 50,000 qualified technologists are needed for laboratories today. The Registry of Medical Technologists lists 23,500 registered medical technologists throughout the country, and approved schools are graduating fewer than 5000 a year.

2. Too many hospital administrators and pathologists hire inadequately or poorly trained technicians under the impression that the few dollars saved on salaries are a real economy for the hospital.

3. There is evidence that this "budget bargain" policy actually results in higher unit costs, because of the greater speed and accuracy with which well trained technologists perform tests, and because the pathologist and chief technologist in a poorly staffed laboratory must themselves perform many procedures that could be delegated to properly trained assistants.

4. The high turnover rate among technologists in hospitals contributes to poor standards and costly laboratory operations.

5. In many cases, however, salary scales are illogical, with well trained, registered technologists doing the same work, for the same pay, as graduates of substandard schools and laboratory assistants with only on-the-job training. This practice adds to low job satisfaction and high turnover.

6. Some medical technology schools among the 646 approved schools maintain required schedules and curriculum standards—but just barely. Students in some schools get the idea they are there to work rather than to learn; the drop-out rate in these schools is high.

7. The approval method for schools, using the services of visiting pathologists in school areas, works better in some areas than in others. Outside the approved schools, there is no way of assessing the training status of thousands of technologists, technicians and laboratory aides employed by hospitals on graduation from commercial schools, or without training.

Of course, these and other conditions contributing to poor laboratory standards in hospitals do not result directly from hospital employment and payroll practice, it is acknowledged. Actually, nobody is wholly at fault. By far the most important contributing factor has been the sudden, mushrooming growth of medical technology since the end of World War II. Many of the problems connected with this growth are similar to those that harass other professions in which the need for trained personnel has outstripped the supply. Medical technology, however, faces an additional complication in that the character of the profession has changed drastically as a result of new demands.

Only a few years ago the procedures performed by laboratory workers in hospitals could be counted on the fingers. Cholesterols, urinalysis, blood counts, a few of the less complex hematology tests, Wassermanns and a little bacteriology made up the list. Today hundreds of tests are performed routinely in pathology laboratories. Moreover, it is a far cry from the day when a colorimeter headed the list of instruments to now, when a technologist is expected to calibrate a spectrophotometer. Laboratory procedures today involve not only operating complicated electronic instruments, but also understanding them.

Specialization of the sort needed today was just beginning five years ago. It is becoming more and more impossible in large hospitals for medical technologists to be expert in all kinds of procedures required. Today specialists are needed in hematology, parasit-

"A review of training programs as they are now conducted is called for"

ology, bacteriology, histology, chemistry, enzymology and other divisions.

It is apparent that a new look must be taken at many aspects of this profession, if the training program is to be tailored to fit the demands that will be made upon it during the next years. As a first step toward this end, the U.S. Public Health Service last month made a pilot grant to a pathologist-medical technologist team, to develop a plan for thoroughgoing study of present needs in medical technology training. This grant will make it possible for members of the Medical Technology Study Committee, half of whom are from the American Society of Clinical Pathologists and half from the American Society of Medical Technologists, to make a careful examination of professional education in an area that has been changing rapidly and undergoing steadily increasing pressures during recent years. Obviously, such a study is much needed.

Here are some of the questions and conditions the study group must consider if it hopes to point the way to solution of today's difficult hospital laboratory problems:

In the face of shortages and other pressures, can the current trend toward higher standards of training be continued?

Last October, for example, the American Society of Clinical Pathologists, which has a big stake in the professional standards of its medical technologists, took a significant step in raising the requirements for medical technologists (as of 1962) to include three years of college, instead of two, plus a year of training at an approved school of medical technology. Actually, four-fifths of the medical technologists applying for certification with the Registry of Medical Technologists, the official certifying body designated by the American Medical Association, are already college graduates. In other words, individual medical technologists were motivated to get degrees long before this need was recognized officially by the professional society responsible for establishing certifying standards.

The impetus for bringing requirements into line with actual practice was probably largely economic. The medical technologists themselves demanded that official requirements be raised, for the very good reason that a college degree in many circles, and this is particularly true of the U.S. Civil Service Commission, is worth more money.

But what of the vast number of so-called technologists, technicians and laboratory aides who do not meet the official requirements of the American Society of Clinical Pathology but who nevertheless work for pathologists?

They come from a variety of training backgrounds. Some have no more than a high school diploma with a few weeks to a year in a commercial school and no hospital training, and many are veterans with a short, armed forces laboratory course and some experience in a dispensary, but unqualified by educational standards for certification. Others have simply picked up their laboratory technics in the course of a rudimentary hospital job. Still others have had science courses in college but no hospital laboratory training. There is no way at present to set standards for such types of training.

How are these technical assistants to be sorted out and categorized in such a way as to protect the hospital patient, who after all is the ultimate consumer of their skills, from poor laboratory work which can not only harm the patient but may actually result in death? Not long ago in New York City such an error on the part of an unskilled laboratory worker in the seemingly simple matter of blood typing resulted in such serious injuries to a patient that the matter was finally brought to court. The court ruled that the hospital was liable for the acts of its laboratory technicians and must pay damages.

What is to keep administrators and pathologists, under pressure for more and more laboratory work and not enough certified medical technologists to do the job, from hiring whatever they can get? How can the sheep be separated from the goats? Shouldn't there be criteria for separating the tough laboratory jobs and the jobs requiring a sizable amount of responsibility from routine laboratory work that can safely be done under the supervision of an adequately trained medical technologist?

Is the registered medical technologist adequately trained? What is adequate training?

Such a question opens up a Pandora's box of other questions. These pertain to extent and type of training, categories of training, course content, opportunities for graduate training and refresher courses, and technical training in hospitals.

Today, the Registry of Medical Technologists requires certain scientific courses of all medical technologists and basic laboratory skills and technics that must be mastered. The two required college years must include one year of inorganic chemistry; three semester hours of quantitative chemistry, organic chemistry or biochemistry; 12 semester hours of biology.

After that, in the year of training in an approved school of medical technology the student must take: biochemistry, hematology, bacteriology, parasitology, tissue technic, serology, urinalysis, basal metabolism, and miscellaneous clinical microscopy.

Because of the many changes that have taken place in this profession within a very few years, a review of training programs as they are now conducted in approved schools is called for.

Are they geared to professional needs? Medical educators themselves today are seriously reexamining the courses offered medical students, and teaching methods. Courses in the paramedical professions deserve similar attention.

What about standards of technical training in hospitals?

Technical training, generally, has a tendency to lean on the methodology of demonstration. In itself this is valuable, if the demonstrator is apt, but it is not sufficient to carry the student from the mastery of a technic to an understanding of its varying applications, or to acquire perspective as to how it fits with a whole galaxy of laboratory principles and problems.

There is no doubt that while there are many splendid schools among the 646 approved for training medical technologists, too many schools live within

"It should help to establish reasonable salary differentiations"

the letter of the requirements but ignore the spirit. They maintain curriculums and strict schedules of hours, but they are behind the times when it comes to teaching.

It is usually these schools that suffer from high drop-outs. Even the loss of a few students is serious in a profession that graduates fewer than 5000 each year. Such schools may well look to their methods of instruction for the answers as to why they are not attracting or holding students. A college that specializes in a pretechnology course in an eastern state, and maintains close liaison with former students attending approved schools of medical technology, reports that while there is a great deal of enthusiasm for some schools, they have stopped sending their students to one where no real teaching is done at all, and where the students are just used to do laboratory jobs.

It is important that this period be a genuine learning experience. If student technologists feel that they are continually acquiring new information and enlarging their backgrounds, they are not likely to think about dropping out. If, on the other hand, students are regarded as little more than extra pairs of hands to perform routine tests for the laboratory, it is not surprising that they lose motivation.

Whether the present method of inspecting approved schools contributes much to their growth and development is another matter for exploration. On this point there is some disagreement. Pathologists who visit schools in their own areas now have an inspection form to guide their evaluation, and, unquestionably, the quality of inspections is vastly improved as a result; often, it is pointed out, the school being inspected is better than the home school of the visiting pathologist, so both schools gain something from the visit. Others insist there is a basic fault in the concept of having brother pathologists inspect each other. "More than likely such a visit will end down the microscope, comparing interesting surgical tissues!" said one observer.

What jobs are we training technologists for?

Registered medical technologists are only one category of clinical laboratory personnel, ostensibly the top category. Are they being used as such in the laboratories where they are employed? How about the workers below the rank of MT (ASCP)? What is their comparative use? Their pay? Their status? Is it worth a girl's while to take the extra training required for certification?

The answer to these questions now varies with the individual laboratory, and for that matter with the individual pathologist. There are different patterns in the East and the West. Unlike utilization of graduate nurses, practical nurses and nurse's aides, which is strictly defined in most hospitals, there is no accepted pattern for the placement of the certified medical technologist, as against others who have come into the laboratory by uncharted routes.

The absence of factual studies on the best deployment of laboratory personnel according to their training for their jobs has led to a vast amount of mismanagement in this area. Frequently a registered medical technologist finds herself doing the same work for the same pay as a technician who has learned on the job to perform one or two tests, but who has no across-the-board knowledge of laboratory work. At the other end of the scale a student technologist can become discouraged working very long side by side (often without pay) with hired laboratory aides who may have no college training, but at least are earning a living wage.

It is obvious that if, after some years of training in college and in an approved school, a technologist finds herself no better off than a colleague who has entered the field with no training, or at best a short stint in a commercial school unaffiliated with a hospital laboratory, she is likely to feel that the investment in time, money and effort is unjustified.

As a first step in making it worth while for students to go to college and then to an approved school of medical technology, it should help to establish reasonable salary differentiations. Some hospitals have found it useful to classify workers in categories. A well staffed laboratory might employ several different classes of technicians.

A pathologist and hospital administrator in a New Jersey hospital, for instance, recently instituted a listing of payroll titles based on the following differentiations: medical technologists (ASCP certified) with and without a B.S. degree; medical technicians, divided into four categories depending on length of experience), and laboratory aides, with no previous technical experience or academic specialization.

Surveys of a number of laboratories, covering qualifications and types of work done, would be helpful in determining general categories that might be recommended. Unless such differentiations on the basis of training are devised, professional problems will continue to plague personnel in this field. If laboratory workers are to be encouraged to meet higher professional standards, the competence implied by certification must be reflected in higher salary schedules for the registered medical technologist.

What about the dollar-conscious hospital administrator or pathologist who makes-do with the cheapest possible laboratory staff? Does this practice really save money? Does it threaten laboratory standards?

Some hospital administrators and pathologists take an attitude that goes something like this: While paying lip service to the theory that registered medical technologists would be fine to have, they accept the need to compromise with lesser help with an alacrity that actually stems from the feeling that they are getting a budget bargain by doing so.

Actually, there is need for a study to establish what if any savings are made this way. For payroll purposes, such employment appears to be economical, but it might be worth finding out whether hidden costs more than make up the difference. It is doubtful that glassware breakage is much of a factor, but there is evidence that tests done in laboratories using top trained workers cost less per unit, because of the speed and accuracy with which they are performed, and because clinicians who have confidence in the laboratory's technical staff do not re-order tests repeatedly. (*Continued on Next Page*)

Furthermore, a laboratory staffed with inadequately trained personnel places a heavy burden on the pathologist in charge and his chief medical technologists, who in the end are forced to perform many of the tasks that otherwise could have been delegated to well trained assistants. Thus time is a factor which cannot be disregarded. In fact, in a recent statewide survey a 300 bed hospital staffed with 100 per cent registered medical technologists had the lowest cost per unit of tests, and it was the only hospital in its category so staffed. Apart from economy, of course, is the most important factor of all—the safety and quality of service to patients.

Another area that could profitably be studied is the turnover rate among medical technologists.

Why do medical technologists move from one job to another so frequently? Could it possibly be the comparatively low salaries? Of course there are other factors, including the preponderance of women in the field who often give up working when they marry and raise a family. It is this high turnover rate, in fact, that tends to discourage some pathologists from putting forth the effort required to procure highly trained help.

One Boston pathologist contends that unskilled workers stay on the job longer. Why anyone would want an unskilled worker longer is hard to say. On the other hand, this should be studied too.

The situation in the federal government needs to be considered.

One of the factors depressing medical technologists' salaries, as well as professional standards, is admittedly the anachronistic situation existing in the civil service designation of this type of work. "Medical Technician 645" is a nonprofessional classification, putting laboratory workers in the same class with clerks, stenographers, and mail carriers. Starting salary is around $225 a month ranging up to a high of $377. Nurses, on the other hand, are classified as professional, starting at $300 and ranging much higher.

This system works in such a way that a nurse, after just three years of nursing school following high school, can become a professional government worker, but a medical technologist may go to college, take a degree and graduate, and yet not be regarded as a professional or eligible for a commission in the armed forces.

The situation stems from the fact that, when these categories were established, all technicians were high school graduates. Today they are likely to have college degrees. But the classifications have not been brought into line with the times.

Current efforts are being made toward having the federal civil service revise its classifications and prepare new qualifications for the medical technologists. This effort needs to be vigorously supported.

One public health pathologist who shares deep concern for raising professional standards in medical technology has even gone so far as to propose that perhaps the most effective way of achieving this would be to establish an entirely new category or series entitled Clinical Pathology Technologist, ranging in professional status from GS-5 to GS-15.

However it is done, the establishment of clear professional status for medical technologists obviously will be given substantial impetus by action on the part of the Civil Service Commission to bring qualifications for this personnel category up to date. As long as the federal government lags behind in accepting medical technologists as professionals, the entire status of the profession suffers accordingly.

A final problem presented in connection with the profession of medical technology is the vast new area opened up by current plans for a nationwide program of cytologic screening.

Recent tests have proved that diagnostic examinations made soon enough can disclose incipient cancer of the cervix, second greatest cancer killer of women. To make such examinations on a broad scale, additional technologists are needed to aid pathologists by screening negative from positive slides. The American Cancer Society has stated that 90 per cent of all deaths from cervical cancer can be obliterated by the wide use of this test.

According to estimates, this means an active staff of close to 6000 cyto-technicians across the country, screening slides daily.

How much training do they need? Some recommend a basis of full medical technology accreditation. Others wonder if it is necessary to deplete the already thin ranks of certified medical technologists in order to recruit technical staff to perform this specialized procedure.

With only 23,500 registered medical technologists throughout the country, and an estimated 50,000 medical technologists needed for laboratory work of all kinds, there is obviously no reservoir from which cyto-technicians can be drawn. Plainly, new sources of supply must be found.

The National Committee for Careers in Medical Technology, founded by the American Society of Clinical Pathologists, the College of American Pathologists, and the American Society of Medical Technologists, has made substantial progress during the last three years in interesting young people in this profession.

It aims at increasing the number of laboratory workers fulfilling training requirements laid down by the A.S.C.P. and the A.M.A., and thus increasing those certified by the Registry of Medical Technologists.

Major recruitment tool has been a vocational guidance film on medical technology, which has been shown throughout the country to science classes and other school and civic groups. It has established a record number of television showings. This, plus wide distribution of informational materials, including brochures, pamphlets and posters, was a major factor in increasing the enrollment in approved schools last year 17 per cent over the year before.

While the committee's efforts have thus begun to show some results, there is still a long way to go. Young people are not going to want to enter this career in sufficient numbers until educational patterns are improved, salaries are made more attractive, and professional integrity is strengthened.

However, a certain burden of proof also rests on registered medical technologists to prove their worth. It is only as standards of training are enforced that the rank and file of pathologists—and hospital administrators—will come to accept the certification of MT (ASCP) for what it is—a category that can become so highly respected that there is no question regarding competition from other levels.

To bring this about, approved schools of medical technology may face a sharper challenge than they have known. They must not only offer the kind of professional training that stimulates continuing growth, but they must also build a career with sufficient attractions to draw a high type of personnel.

How to extend current efforts in this direction is an urgent problem faced today in this profession. If the study can contribute toward solving it, it will have made a major contribution to medical progress.

THE MODERN HOSPITAL OF THE MONTH

Howard M. Hanna Pavilion, the new psychiatric unit of University Hospitals in Cleveland. This month's cover picture is the lobby of the Hanna Pavilion. The architects for the new unit were Garfield, Harris, Robinson and Schafer of Cleveland.

Psychiatric Unit Offers Integrated Care

Hanna Pavilion for mental and emotional disorders is the newest addition to a medical center in which the objective is to provide total care for patients

ERNEST C. GRAY Jr.

THE Howard M. Hanna Pavilion, dedicated last April, is the newest addition to a fast-growing medical center affiliated with Western Reserve University, Cleveland. University Hospitals and Benjamin Rose Hospital for geriatric problems constitute the great clinical area of this center. The new building is devoted entirely to the treatment of mental and emotional disorders of an acute nature.

The importance of this type of unit in a general hospital setting is great; it provides another link in the total treatment of the patient. Patients who have both a physical and mental problem can be treated in both areas rather than just one. The patient who develops an emotional disorder as a result of a physical problem can likewise be more adequately handled.

The pavilion is of reinforced concrete construction finished in brick with stone trim and aluminum sash. There are large windows in both patient and office areas. The unit is connected to Lakeside Hospital (the central building of the University Hospitals group) by a tunnel at the basement level of each building and by a bridge which runs from the third floor of the pavilion to the second floor of Lakeside. The ground on which the pavilion is built is at a lower level than that of Lakeside Hospital.

Acutely disturbed patients are housed on the fifth floor. Those who are mildly disturbed are on the fourth floor, and those who are about to be discharged or who have psychosomatic

OUTLINE OF CONSTRUCTION COSTS

Total project cost		**$2,632,049.74**
Number of beds	**90**	
Cost per bed		**29,245.00**
Total square feet	**82,000**	
Square feet per bed	**911**	
Cost per square foot		**26.40**
Total cubic content	**1,000,000**	
Cubic feet per bed	**11,111**	
Cost per cubic foot		**2.16**

Mr. Gray is assistant to the director, University Hospitals, Cleveland.

Waiting room in the children's outpatient clinic, showing one of four murals depicting the four seasons of the year. These murals were painted and presented to the hospital by Harriet House. This clinic has a separate entrance.

This pleasantly furnished room, equipped with couch for patients, is typical of the offices provided for psychiatrists. Some of the offices are grouped in suites so that two share a waiting room; but each of the offices has its own exit.

problems are housed on the third floor. The building is air-conditioned in all locked units, as well as in the outpatient clinics. Air conditioning is provided entirely by ceiling grilles.

Music and radio have been built into the building. For this purpose four channels of AM-FM radio are available, and one channel for records has been provided. The control unit for this system is located in the nurses' lounge on the fifth floor. The music is piped to patients' rooms, tub rooms, day and sun rooms, the occupational therapy unit, floor dining rooms, and floor waiting rooms.

Another built-in feature is the closed-circuit television system. The reception outlet for this is in the amphitheater on the first floor. Input stations are on the second, fourth and fifth floors. These stations are located in rooms adjoining treatment and recreational areas. The system is designed for medical teaching. Thus the student can observe a patient being interviewed, being given a therapeutic treatment, or simply at play. In some areas it is planned to conceal the camera, in others no concealment will be attempted. In the former cases the camera will televise through one-way glass mirrors. The reception of the television picture will be either on a large screen television set or projected on a separate large screen.

Music and radio have been built into the building. There are four radio channels and one record channel. The control is located in the nurses' lounge.

A pneumatic tube system has been installed between the Hanna Pavilion and Lakeside. There are tubes of both standard size and extra large for carrying charts. Outlets are in both the outpatient clinics and on each nursing unit.

A telautograph connects the outpatient clinics with the central OPD record room in Lakeside. This provides fast service for patients' charts.

The building forms a U in shape and in the center of this U, on a level with the basement of the building, is a sunken court designed entirely for patients' use. The only access to this court is from the building. The court is framed on three sides by the building and on the fourth side by a 5 foot retaining wall. The court is completely landscaped and provided with outdoor court furniture.

The subbasement and two penthouses contain most of the machinery for the elevators, ventilation and water for the building. Heat, light and power, as is true for the rest of University Hospitals, are derived from the Medical Center Company, a separate nonprofit organization which provides these services for all the nonprofit institutions in the area.

On the basement level is located the research laboratory area consisting of 17 laboratory rooms, a darkroom, a workshop, a volatile storage room, animal storage and animal operating rooms, several walk-in refrigerators, and three offices.

Also on the basement level is the main kitchen. Food service for this building comes from the main kitchen in Lakeside Hospital by means of hot and cold carts. When the food arrives it is transferred from the carts to wells along a moving belt assembly line. Patients' trays move along the belt for tray makeup and thence via conveyor to the various floor kitchens from which the patients are served.

There is a kitchen on each patients' unit which is used for the serving of meals and also can be used as a therapy device for the patients. Each kitchen is equipped with an electric range and refrigerator and two of them have ice cubing machines. Each kitchen is stocked with dishes and silver.

All special diets are prepared in the main kitchen of the building and to this end the kitchen has been completely equipped. A separate dumb-waiter has been provided for the return of dirty dishes to the dishwashing area of the kitchen.

Other sections of the basement level have been assigned lounges for various personnel. Each of the women's lounges is equipped with a powder bar and furniture designed for rest in short relaxation periods. All lounges have adjoining locker rooms.

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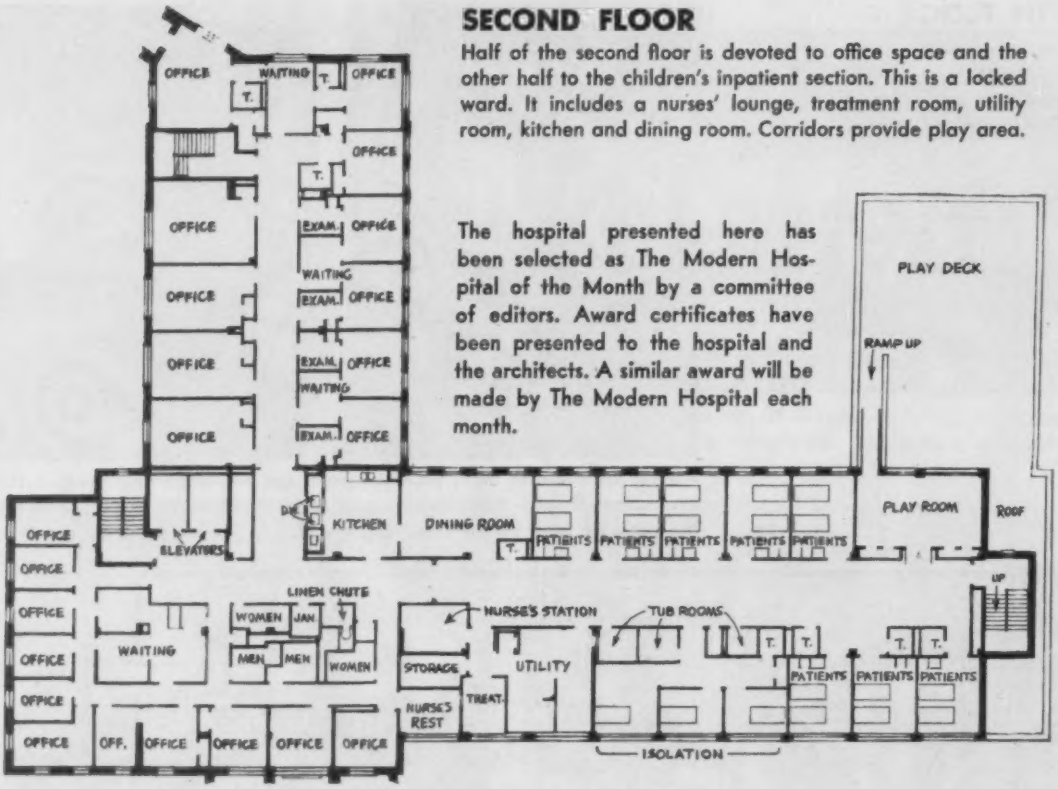
SECOND FLOOR

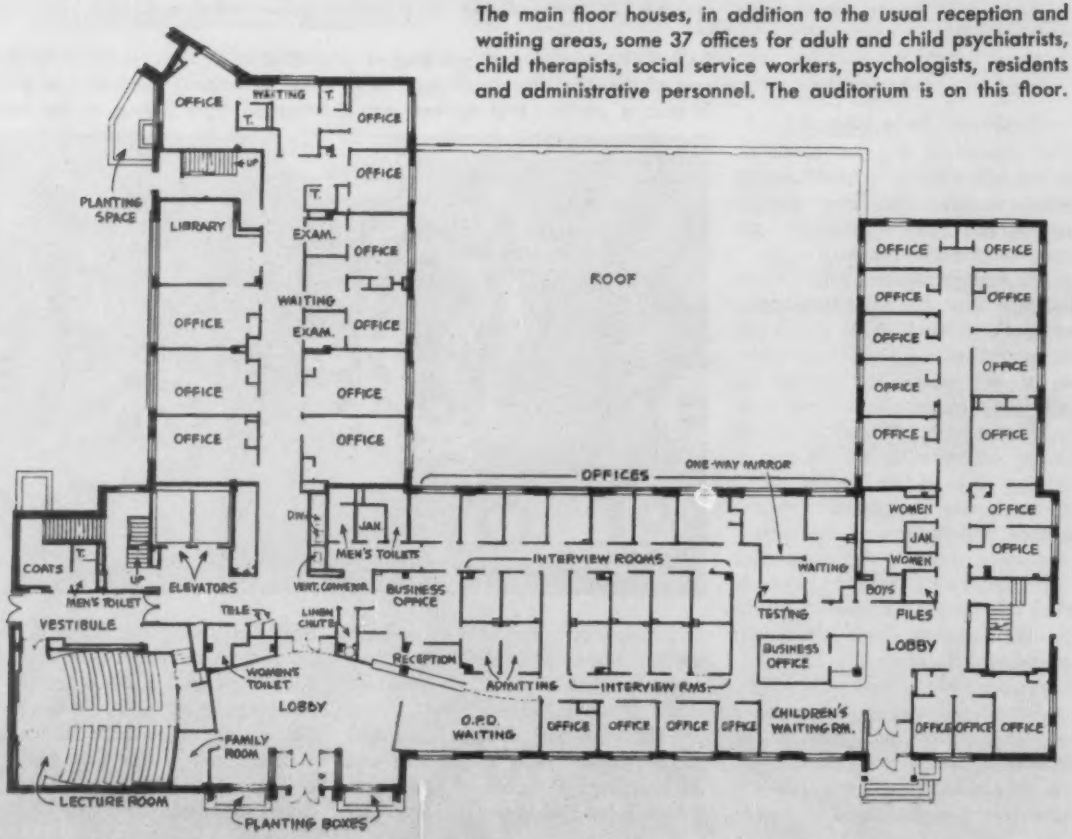
Half of the second floor is devoted to office space and the other half to the children's inpatient section. This is a locked ward. It includes a nurses' lounge, treatment room, utility room, kitchen and dining room. Corridors provide play area.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital and the architects. A similar award will be made by The Modern Hospital each month.



FIRST FLOOR

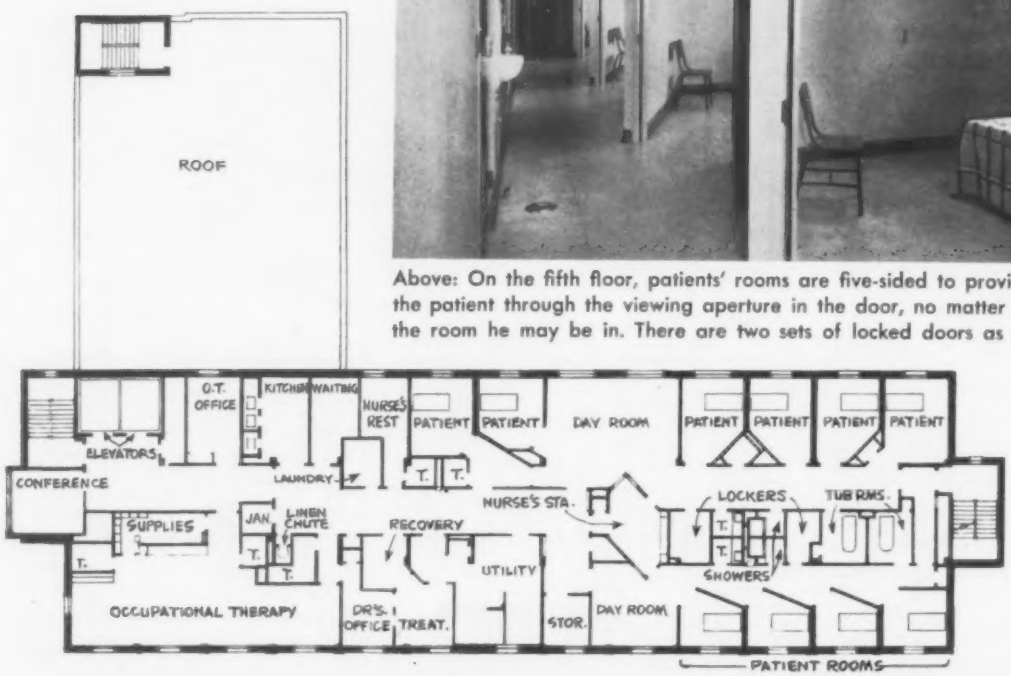
The main floor houses, in addition to the usual reception and waiting areas, some 37 offices for adult and child psychiatrists, child therapists, social service workers, psychologists, residents and administrative personnel. The auditorium is on this floor.



FIFTH FLOOR

Acutely disturbed patients are housed on the fifth floor, which has several unusual design features, including the segregation of the working corridor.

Above: On the fifth floor, patients' rooms are five-sided to provide a view of the patient through the viewing aperture in the door, no matter what part of the room he may be in. There are two sets of locked doors as a safeguard.



Below: The nursing station is placed at a 45 degree angle to the flow of the rest of the floor, thus providing views in all directions. Windows are placed in such a position that patients are discouraged from staring at the nurses.

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The remainder of the basement provides space for the housekeeping supervisor's office and linen storage, soap storage, general storage, and various mechanical spaces.

A 90 seat amphitheater is located on the first floor. The room is equipped for closed-circuit television, movie and slide projection, and blackboard space. One of the special features of the room is a rheostat light control so that lights may be illuminated at any level of intensity desired. The amphitheater is so situated in the building that it may be used for evening functions without having the participants enter through the main part of the building. This area can be locked off, having an entrance of its own off the main drive and special coat checking facilities.

The main lobby is modern in feeling as is the whole building. It is paneled in a light natural mahogany veneer. The floor is terrazzo with carpets used with certain furniture groupings. Off to one side is a small family room to provide privacy when it is needed. On the other side is a stationary screen which partitions the lobby from the adult outpatient waiting room.

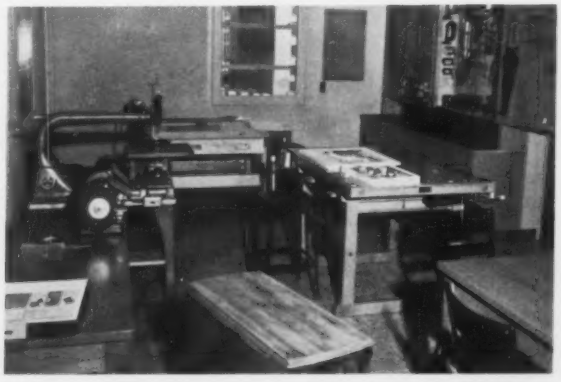
This lobby and its reception desk accommodates adult outpatients and all inpatients. Payment of patient accounts is handled in the business office behind the reception desk. An admitting office for the inpatient sections and an evaluation office for the outpatient units open off this area as well. The evaluation is a financial one rather than medical.

There are 37 offices on the first floor providing space for adult and

A summery, cheerful atmosphere is engendered in the sunrooms by the use of gay wallpaper and tubular furniture.

This patients' dayroom, with the piano and informal grouping of furniture, looks more like a club than a hospital.

The dayroom for acutely disturbed patients is equipped with piano, ping-pong table, and card tables for patients.



The occupational therapy unit, located on the fifth floor, has facilities for ceramics, woodworking and weaving.

child psychiatrists, child therapists, social service workers, psychologists, residents and administrative personnel. In addition, there are 10 interviewing rooms and a psychological testing room with one-way glass.

One of the unique features of the office area on both the first and second floors is the use of the suite arrangement for some groups of offices. Two offices share a common waiting room. However, each office has an exit of its own. Therefore, the patients enter the office through the waiting room and leave through a separate exit, permitting the patient to regain his composure before entering the public corridor and preventing contact between entering and departing patients.

The children's dining room, showing one of the scenes from a Walt Disney animal film.

There are two patient entrances in the front of the building. One of these is for inpatients and all new patients for the outpatient clinics. However, a separate entrance has been provided for children to use after their first visit. This entrance has its own lobby, reception desk, business office, and waiting room.

A completely paneled and carpeted library has been provided. The psychiatric library is a part of the general medicine library in Lakeside, but certain reference books and periodicals will be kept in this building. The main purpose of this room is to provide an excellent place for writing and research.

Half of the second floor of the building is devoted to office space and the other half to the children's inpatient section; 22 offices are provided on this floor for psychiatrists, nursing, house staff, and social service. There are seven rooms throughout the hospital assigned exclusively for

(*Continued on Page* 140)

Patients Are Making Progress Under the Home Care Program

First report on the experiment made by San Francisco hospitals

IN ITS first six months of operation, the San Francisco home care program has demonstrated it can do a better and less expensive job of caring for some kinds of patients than a regular institution, according to officials of Mount Zion Hospital, San Francisco, where the program originated.

A report on the first six months of operation revealed that it has been possible to provide 32 demonstration patients with total medical care, integrated with physical and occupational therapy, vocational rehabilitation, social welfare and other services, *in their own homes,* to a greater degree than could be provided for them in any hospital in the city—and at less cost, Mark Berke, director of the home care program, pointed out. Mr. Berke also is director of Mount Zion Hospital.

Above: At Mrs. Condrin's home the nurse instructs her on how to apply injections. The team physician visits Mrs. Condrin once or twice a week.

Above: At a weekly conference, the San Francisco home care staff discusses the case of Mrs. Gladys Condrin, who was hospitalized for a diabetic condition that led to the amputation of her right leg. Mrs. Condrin was able to leave the hospital and return to her family (invalid husband and two teen-age sons) because of the facilities afforded her by the program.

Right: The physical therapist applies the weights properly so that Mrs. Condrin can exercise her leg preparatory to receiving a prosthetic leg to be supplied by Vocational Rehabilitation Bureau.

"All of this has served to help reduce for these patients the tremendous emotional and financial drains of chronic illness on patient, family and the community," he said, "at approximately one-fourth of what it would cost for the same services in a private voluntary hospital, and half of what it would cost at San Francisco Hospital."

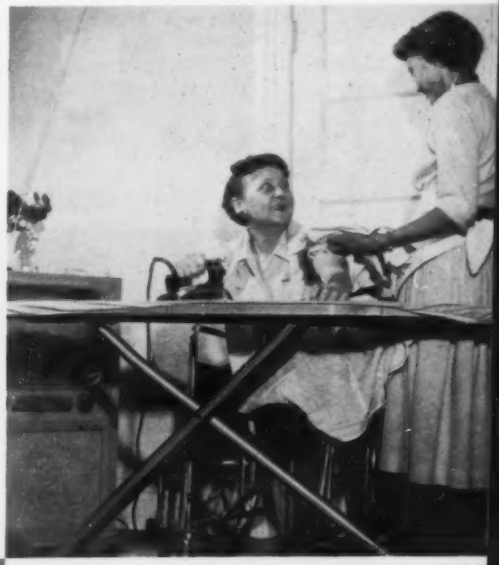
The progress report revealed that in its first six months the home care program has enabled 32 carefully selected patients, who otherwise would have had prolonged or repeated hospitalization, to be treated at home by a visiting team of doctors, nurses, social workers, physical and occupational therapists, vocational counselors and housekeepers — working together as a team with a corps of physician specialists and psychiatrists as consultants. Of these patients, four have regained the ability to walk unaided; six are now able to do much more to take care of themselves at home; three have had their period of hospitalization reduced because of the opportunity to get hospital care at home, and for 23 the goal achieved has been to delay or prevent their becoming permanently institutionalized. Six already have been able to make use of some vocational rehabilitation services to start training for new jobs.

There has been an increasingly widespread interest in the program from all sections of the community. The home care program reported 74 referrals and 114 inquiries in the six month period from more than 20 social agencies—including Family and Children's Agency, Catholic Social Service, and Jewish Family Service—from almost every hospital in the city, the Visiting Nurse Association, the Red Cross, Salvation Army, San Francisco Cancer Society, and from private physicians and families of patients.

Patients now range in age from 16 to 91, with more than half of the group composed of older people. Principal disturbances have been strokes, fractured hips, cardiac conditions, and neurological diseases.

As a test pilot program, efforts have been concentrated on patients from two local hospitals—a public one (San Francisco Hospital) and a private voluntary one (Mount Zion Hospital). One-third of the patients treated at home under the program have been referred from San Francisco Hospital.

Above: Therapist helps Mrs. Condrin onto her crutches. Since she has been at home Mrs. Condrin has learned to go up and down stairs, get in and out of bed by herself, and use a wheelchair to get around inside the house, none of which she was able to do when she first came home.



Below: Mrs. Condrin does leatherwork, in this case a wallet for one of her sons, with the help of the occupational therapist who visits her once a week.

Above: Mrs. Condrin does most of her own housework, all of the cooking and ironing and dishwashing, with a housekeeper coming in once a week to do the heavy work. Social service workers are also helping Mrs. Condrin with various family problems arising out of her illness.

47 Casualties Treated in 32 Minutes

Speed and dispatch in coping with casualties distinguished this disaster exercise in which the hospital cooperated with community agencies

DONALD R. NEWKIRK

EXACTLY 4 minutes following a simulated "explosion" on the fairgrounds of Fremont, Ohio, Sept. 5, 1956, fire-fighting equipment, ambulances, rescue squad and police vehicles, a Red Cross station wagon, two town doctors, and a Civil Defense mobile field hospital were on the scene of the disaster. In another few minutes casualties had been tagged and were on their way to the hospital. A National Guard truck preceded the first ambulance on its route to the hospital, dropping off uniformed and armed guardsmen to stop traffic for the vehicles that were to follow. The first ambulance arrived at Memorial Hospital 9 minutes after the explosion. Many citizens of Fremont followed the ambulances to Memorial Hospital, parked and got out to watch the arrival of casualties. Spectators who walked across the hospital lawn to the scene of activity were handed a short letter on hospital stationery explaining that they were witnessing a practice disaster exercise to test the working efficiency of the community's disaster-civil defense agencies.

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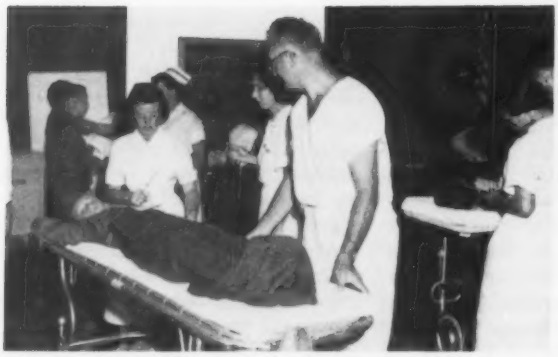
Mr. Newkirk is assistant administrator, Memorial Hospital of Sandusky County, Fremont, Ohio.

A simulated explosion, accompanied by noise and thick smoke, started the disaster exercise at Memorial Hospital.

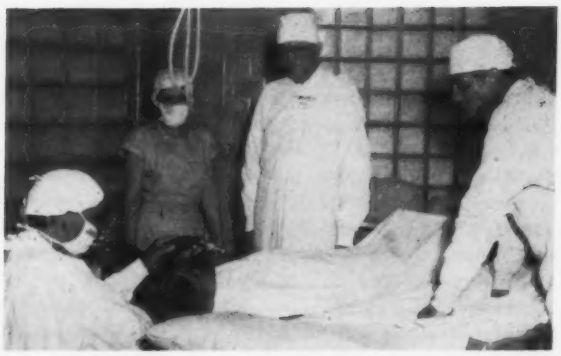
The rescue wagon arrives at the hospital's unloading zone with the first casualties. Other vehicles arrived soon after.

Shown waiting at the fairgrounds for the disaster exercise to begin are vehicles and personnel from 21 organizations.

Casualties were carried or assisted from the unloading zone (the doctor's parking lot) into the sorting area.



Patients in receiving section are being identified, sorted and made ready for transportation to the treatment areas.



Casualties who were tagged as surgery patients actually were taken to surgery where the team was ready for them.

Radio communications set up on the lawn provided direct contact with both the disaster scene and the vehicles.

Communications during the disaster exercise were handled by telephone switchboard, paging system and messengers.

OPERATING PROCEDURE—LOCAL DISASTER PLAN

Outlined below is the plan for the participation of Memorial Hospital in case of a local disaster (tornado, train wreck, theater fire). A sudden disaster, creating demands upon the hospital which could not be met by routine procedures, makes this plan for treatment of casualties absolutely necessary.

BASIC ORGANIZATIONAL PLAN:

There are four basic units of organization for the operation of the disaster plan. Each organizational unit has a unit head (listed below). Unit heads will carry out activation of the plan and will supervise the disaster program after activation. The units of organization are: (1) executive, (2) medical, (3) nursing, (4) service.

ACTIVATION OF DISASTER PLAN:

If we are fortunate enough to receive advance notice of the arrival of casualties from a disaster scene, the notification will probably be by telephone. If no advance notice is given the hospital and a sudden influx of emergency patients is the first indication of a disaster, it is *extremely important* that one of the ambulance drivers, police authorities, or other person bringing patients from the scene of disaster report immediately to the switchboard so that the plan may be activated. As soon as the switchboard operator has determined that a disaster condition may exist, she will:

1. Tell the person phoning to stay on the line and not hang up. (In the excitement at the scene of the disaster the person phoning may hang up without giving location, approximate number of casualties, types of casualties.)
2. Transfer call to *Executive Officer* in charge of hospital at the time of disaster.
3. After *Executive Officer* completes initial telephone conversation with disaster scene, contact *Executive Officer* for further instructions.

After receiving information from the switchboard that there is a possibility of a disaster condition existing, the *Executive Officer* will:

1. If possible, verify the nature and extent of the disaster.
2. Have the switchboard begin phoning key personnel, using priority list kept at switchboard, and either inform personnel that a disaster *may* exist (semi-alert) or that a disaster *does exist.*
3. Evaluate situation and estimate necessary degree to which plan should be activated. The estimated number and severity of casualties will determine this.
4. Set up and man a communications center.
5. Supervise preparations for receiving casualties.

Upon receipt of information that a disaster has occurred, the *Medical Officer* will:

1. Report immediately to receiving station.
2. Estimate his needs in the situation and inform communications center which doctors to phone for assistance.
3. Remain in receiving area until patients and/or medical assistance arrives.

Upon receipt of the disaster alert the *Nursing Officer* will:

1. Report immediately to receiving station.
2. Set up communications either by messenger or telephone with the personnel assembly area for nursing personnel.
3. Evaluate the quantity and types of nursing personnel on duty, estimate needs, and begin immediate redistribution of nursing personnel.
4. Determine the need for auxiliary help to perform services such as: (a) transferring of patients; (b) setting up of cots and beds; (c) delivery of supplies; (d) provision of clerical assistance.

Upon receipt of the disaster alert the *Service Officer* will:

1. Immediately report to the *Executive Officer.*
2. Activate, supervise and coordinate all service units of the following: (a) administration, (b) central supply, (c) dietary, (d) housekeeping, (e) laboratory, (f) laundry, (g) maintenance, (h) medical records, (i) pharmacy, (j) physical therapy, (k) purchasing and stores, (l) x-ray.

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The large crowd which gathered at the scene of the "disaster" seemed no less interested when the smoke cleared and revealed 85 uniformed boy scouts lying on the ground. There was no blood, no one was hurt, and a few restrained laughs were heard as nurses and doctors passed among the "victims" asking questions, affixing tags to an arm or leg, and poking here or there to "see if it hurts."

Some casualties needed life-saving first aid. This was acomplished by the use of field hospital equipment and personnel from C.D. and Red Cross units. Some casualties were classed as slightly injured needing only first aid. These were "treated" and then treated again to a soft drink provided by the emergency feeding unit of the C.D. corps. Forty-seven "injured" were evacuated to Memorial Hospital.

Instead of expending energy to keep observers from entering treatment areas, as would be done in a real situation, we invited interested visitors to follow the casualties through the hospital disaster procedure. Entering a side door to the ground floor of the hospital the visitor followed a stretcher to the receiving and sorting area, located in a large suite of rooms adjacent to the outside entrance and normally used for a board room and library. The litters were placed on the floor and the "patients" were lifted onto a wheeled stretcher or table. From one side of the room came the barely audible voice of a radio news announcer broadcasting a commentary on the proceedings as "casualties" were treated.

After identification and classification of injuries patients were moved to areas designated, equipped and manned to care for shock, burns, minor injuries, orthopedics, x-ray, minor surgery, major surgery and obstetrics. Some of the casualties were sent directly to the morgue.

IN THIS DISASTER PLAN STUDENT NURSES ARE THE LINK BETWEEN

FOR more than a year, a disaster committee composed of representatives of the medical staff and key hospital personnel at Fairview Park Hospital, Cleveland, has been studying the planning already completed by others in the field and reviewing the experience of hospitals involved in disasters of the past several years. A simple, workable master disaster plan evolved from this study.

The major items that must be planned for are as follows:

Personnel: (1) immediately on hand (in hospital); (2) personnel pool (ready reserve); (3) personnel on call (secondary reserve).

Patient flow, including receiving, sorting, treatment and disposition of casualties.

Traffic control: (1) internal (in hospital—includes hospital personnel, visitors, families, prior patients, and the press); (2) external—in immediate vicinity of hospital.

Evacuation of prior patients (mass discharge within safe limits).

Mr. Seifert is administrator of Fairview Park Hospital, Cleveland, and Mr. Gerber is a public relations consultant of Cleveland.

Communications. Upon notification that the hospital will receive nine or more casualties, the switchboard operator uses paging system to notify all personnel. Our code is, "Dr. White—25." The code "Dr. White" is the disaster plan; the number indicates the number of casualties which have arrived at the hospital or have been reported on the way. Immediately after announcing the disaster code, the control or communications center (in our case, the business manager) begins to alert key personnel, including members of the medical staff disaster team. The communications center takes possession of central pay phones for all outside calls. For internal calls, the internal dial system is used.

When key personnel is named, it is assumed that the senior persons under them and on duty take over their functions until the named persons can appear at the hospital, in the event they are absent from the building at the time of disaster. All key personnel is called and expected to return to the hospital immediately. All members of the disaster team begin preassigned duties at once. Litter carriers transport an emergency supply of litters to

"Disaster" scene in NACA Lewis Flight Propulsion Laboratory where casualties were given first aid after "attack."

Laboratory disaster team members held their own civil defense drill, caring for patients before they went to hospital.

Thirty-two minutes after the first casualties arrived at Memorial Hospital all [47] had been "treated" and were on their way home, emergency equipment and supplies were returned to their storage places, employes had returned to their regular jobs, and it was just another hot, humid September afternoon.

Primary planning for the disaster exercise had been started in the community two months earlier with a meeting of the hospital representative, the civil defense director of Sandusky County, and the Ohio area director for civil defense. At this time the scope and purpose of the exercise, the date and time, and general plans for organization were discussed and agreed upon.

Early in the proceedings, hospital officials realized that whatever type of plan was put into operation its success would be dependent to a great extent on its integration with outside facilities. With this in mind, plans were initiated by outlining in some detail the who-what-why-when-where of disaster planning to the hospital board of trustees. A brief outline of the hospital civil defense exercise was also presented to the board and official and unanimous endorsement was given.

After the trustees' meeting hospital planning began in earnest. Working from the basic organizational outline, definitive planning began with a series of meetings with doctors and all employes. A flip chart was used for the "warming up" process, and the accompanying list of questions and answers giving general information in a palatable form was also distributed together with copies of the organization plan. General meetings were followed by a meeting of unit heads who were given a printed assignment form containing names of all employes in their units. Each unit head was asked to complete the form giving assignments,

(*Continued on Page* 68)

THE PATIENTS AND THE TREATMENT TEAM

VERNON D. SEIFERT
WARREN GERBER

the receiving and sorting section (our outpatient department), prepared to transport patients as ordered. All visiting staff members present in the hospital report to the receiving and sorting station, where a senior medical staff member assigns both visitants and house staff members to duty stations.

The auditorium is converted into an emergency treatment center with appropriate prearranged equipment and personnel assignments. Communications center personnel sets up physical barricades across closed corridors according to the prearranged plan and also prepares for emergency record control and collection of information at the control desk. The center handles all communications. Public information given on a casualty victim is limited to name, street address and general description of injuries, *i.e.* internal injuries, burns, fractured extremities.

All reserve nursing personnel is assigned to the reserve pool established and maintained in the central nursing office. Student nurses are assigned to the secondary pool adjacent to the receiving and sorting area. Secondary pool personnel (student nurses) is assigned to each patient as he leaves the sorting area, unless the casualty is routed to the first-aid facility only.

The student accompanies the casualty to the point of intensive treatment. Final disposition is at the morgue, nursing unit, or surgery. When the patient has been admitted to the proper unit, the student returns to the secondary pool. The primary pool supplies the emergency treatment center, surgery or nursing units as required. Internal traffic is controlled by hospital personnel. External traffic is controlled by police or civil defense auxiliary police.

Two members of the house staff are assigned to clear the nursing units of prior patients in our mass discharge routine. The first units to be cleared are our short-term elective unit (23 beds) and maternity (48 beds). Clearing of medical and surgical units follows as required. All prior patients are discharged through a separate exit where a temporary discharge desk is established.

All casualties, even those to whom first aid is all that is given, must clear through the temporary discharge center

Trucks, station wagons and private cars were used to rush casualties from the hangar to Fairview Park Hospital.

Victims were turned over to hospital personnel upon arrival and were examined immediately by the resident on duty.

MEMORIAL HOSPITAL OF SANDUSKY COUNTY ANSWERS QUESTIONS ABOUT

Q. What Do We Mean by "Local Disaster"?

A. For the purpose of this plan a local disaster is defined as any situation in which the victims reach the hospital in such numbers or are so concentrated in a period of time, or with such severity of injury or disturbance, that their prompt, adequate hospital care creates demands upon the hospital which cannot be met by the hospital's routine treatment and admission procedures.

Such a disaster may be sudden, one that strikes with little or no warning, such as a tornado, an explosion, the collapse of seating stands at a football game, or it may be forewarning in nature, such as a flood, a hurricane, or an epidemic.

Q. Why Must We Have a Disaster Plan?

A. Provision for adequate hospital care to the injured at the time of a local disaster in our community is a responsibility inherent upon the hospital. The efforts of a hospital which lacks a definite plan to meet emergency demands are almost sure to result in confusion and in a haphazard program, with attending deficiencies in the quality of patient care.

Therefore we *must* have in operation a realistic plan for meeting the demands for emergency hospital care, and all personnel involved in the operation must be thoroughly familiar with the plan.

Q. How Will We Know When a Disaster Occurs?

A. Notification will invariably come from a source outside the hospital, and may come from a person who lacks full knowledge of the facts. A semi-alert should be established until accurate details are obtained concerning the nature and extent of the emergency. The semi-alert will consist of merely informing key personnel that a disaster situation may exist and that they should be prepared to activate the disaster plan.

Q. How Can We Verify the Nature and Extent of the Disaster?

A. This may be done by a telephone call to local or state police, fire department, or other safety officials, to the site of disaster, or to a location known to be near the site of the disaster.

Q. How Should We Alert Key Personnel?

A. (a) Set up the switchboard as a communication center and see that it is manned immediately and continually. Communication, internal and external, *must* be kept open at all times. Three or four members of the disaster team will be assigned to the communication center to assist the switchboard operator as messengers, receptionists, etc.

(b) If disaster information is unverified, notify key personnel of semi-alert and possible operation of plan.

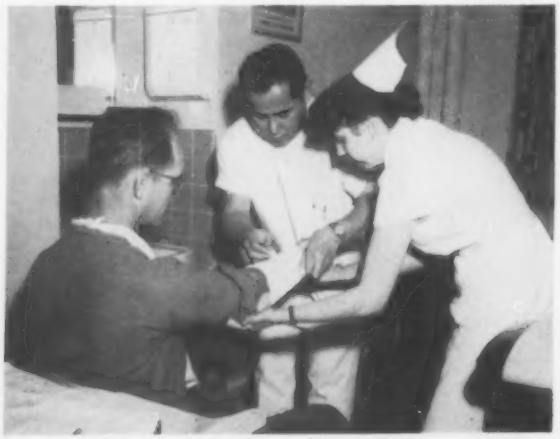
(c) If information is verified, place plan into operation at once to the extent indicated by facts obtained.

(d) Have switchboard (communication center) phone a list of key personnel in order of priority. If some key persons are not on duty, see that they are informed by telephone at their off-duty phone.

before leaving the hospital. At this center, the final copy of the emergency medical tag is collected. At least one member of the medical support team is assigned to this station to assure that patients can be released without harm. This constitutes one more check to assure proper treatment.

Control over records, pertinent patient information, and so forth, is one of the most difficult problems. The condition of a patient often makes it impossible to identify him. A search of his wallet and pockets may be indicated. Reponsibility for safeguarding the valuables of patients is assumed by the student nurse, who as rapidly as possible delivers valuables to the control center where our "valuable package procedure" is used.

The student nurse becomes the principal contact with the patient and is the vital, continuous link between the patient and the treatment team—often becoming involved in the treatment itself. The assistant administrator assumes the responsibility for checking all functions of the support-



A "broken arm" was set in the emergency room. Patients were sent here, to the morgue, or to the auditorium.

Oxygen was administered to patients in the auditorium, which had been converted into a receiving ward.

THE WHAT, THE WHY AND THE HOW OF DEALING WITH DISASTERS

Q. How Do We Get Ready to Receive Patients?

A. Prepare areas for use as *Receiving Station* and *Treatment Areas.*

(a) *Receiving Station:* Patients will be examined, sorted and transferred from the receiving station. To eliminate the possibility of a serious bottleneck it is extremely important that patients be immediately dispatched to a treatment area, and not worked up, treated or identified at this point.

(b) *Treatment Areas:* These should be set up to treat major medical, major and minor surgical cases, walking injured, shock, burns and fractures. These areas, insofar as possible, will be easily accessible to receiving station and near transportation to O.R., laboratory and x-ray.

Q. What Other Preparations, Time Permitting, Should Be Made Before Patients Begin to Arrive at the Hospital?

A. The following preparations should be made by specifically designated personnel in advance of the arrival of the first patients:

(a) *Records and Indentification:* Emergency record jackets should be placed at receiving station and affixed to each patient entering receiving station. In treatment area (not receiving station) clerk should complete identification and index card, inserting the original in patient's record jacket, sending first copy to medical records and second copy to information center.

(b) *Information Center:* This should be set up in a location near the switchboard.

(c) *Morgue:* An area should be set up as a temporary morgue with a responsible person in charge.

(d) *Blood:* Since a disaster may create an immediate demand for a large supply of blood, provision should be made to handle a large number of donors; therefore the Red Cross and other sources should be contacted for rapid delivery of blood and blood expanders.

(e) *X-Ray:* Provision for ample additional supplies must be made and a plan for movement of traffic through x-ray should be activated to reduce confusion.

Q. Will the Disaster Affect Patients Already in Our Hospital at the Time of the Alert?

A. Definitely, yes. When it is known that a disaster has occurred and that the potential load of casualties will exceed the hospital's present capacity, immediate steps should be taken to expand the facilities of the hospital by:

(a) Discharging diagnostic, postnatal and observation cases, patients about to be discharged, and babies after 48 hours postpartum.

(b) Transferring nondisaster patients to other areas of hospital to help centralize treatment of disaster victims.

(c) Restricting and deferring routine admissions.

(d) Adding beds and cots to existing facilities.

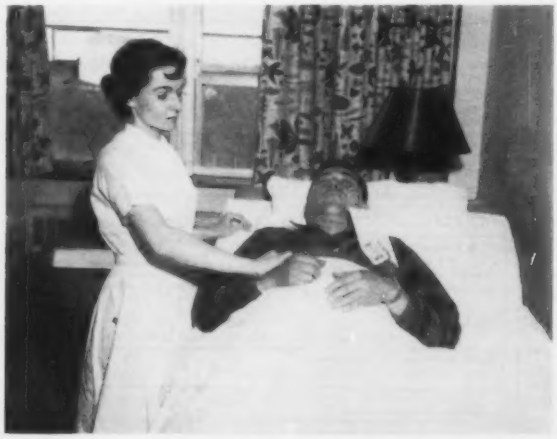
Q. How Will We Obtain Adequate Medical Staff Help?

A. Second on the priority list for notification of the disaster will be the radiologist or his designate. The chief of staff will then see that other members of the staff will be called as needed.

ing services such as x-ray, laboratory, even flow of equipment and supplies. Major responsibility for the development and satisfactory conduct of the plan rests with the assistant administrator. This leaves the administrator free to give over-all supervision as required.

In the event the number of casualties exceeds the beds available following mass discharge (only patients who can be discharged safely are cleared for discharge), the school of nursing is evacuated for emergency bed care. Up to 74 additional beds can be made available in this step. After the first trial run of the plan, in which student nurses were used as casualties, the disaster committee decided to organize a drill that would duplicate actual disaster conditions under as realistic circumstances as possible. The accompanying photographs show how this drill, conducted in cooperation with the National Advisory Committee on Aeronautics-Lewis Flight Propulsion Laboratory, was carried out.

X-ray team went through all of the normal emergency steps in handling casualties whose "condition" called for x-ray.



Final step in the civil defense drill at Fairview Park Hospital was assigning the casualties to beds on the fifth floor.

(*Continued From Page 65*)

stations, alternates (if needed) and so on to each employe. Numbers and types of personnel to be assigned each area were decided upon by the medical unit head.

Every employe was given a specific task to do. A scale map was drawn of the hospital buildings and the area surrounding the hospital; on this map was drawn the pattern for flow of external traffic, streets to be blocked, and heliport area. A large scale drawing of the inside of the hospital was made and areas were designated for sorting, morgue, treatment, and communications. From the employe assignment sheets a master chart was developed with column listings of: (1) unit, (2) station, (3) location of station, (4) number and type of personnel assigned, and (5) duties.

This master chart served as a guide and quick reference for all stations and personnel and was actually carried by each unit head on a clipboard through the exercise. An identification kit, made from an old bedside table, was assembled and kept in the area designated for receiving and sorting. The kit is plainly marked and contains the following items:

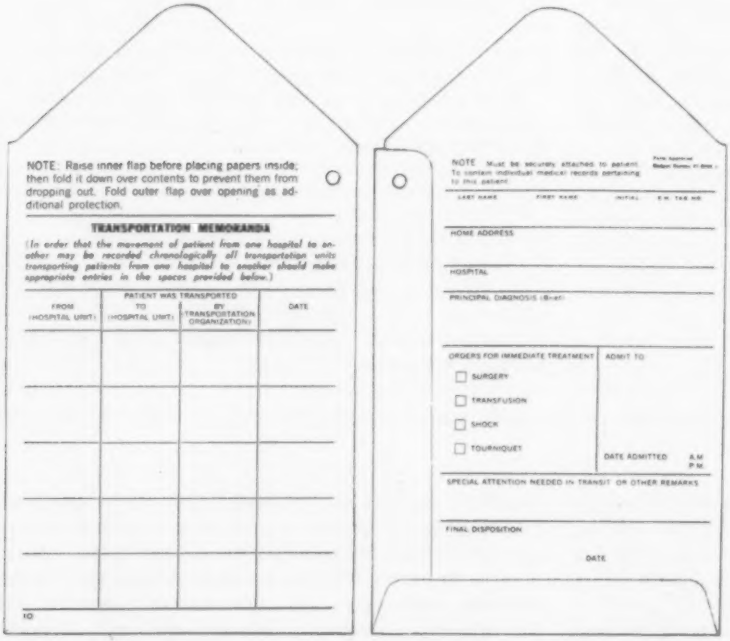
1. Identification tags.
2. Identification forms.
3. Skin marking pencils.
4. Black lead pencils.
5. Large paper bags (for clothing and valuables).
6. Signs reading "Shock," "Burns," "Minor Injuries," "Up Traffic Only," and so forth (to be taped on wall outside converted areas and elevators).

Unit heads organized their various sections with the aid of letters, memos, meetings, telephone calls—practically any means to arouse interest. The medical unit head planned a campaign which netted excellent interest and participation by the entire medical staff. The nursing unit head did a superlative job of organizing and assigning her personnel and helping to develop a list of supplies to be taken to the treatment areas by nursing employes as they report to their duty stations.

The culmination of disaster planning activities in the hospital was a practice drill one week before the "big show" at the fairgrounds. Advance notice was given employes and doctors and the time set for the drill was immediately after the lunch hour. The doctors were invited to attend lunch that day, and after a final briefing "Dr. Red" was announced calmly on the public address system and the exercise was under way. Results of the first drill were excellent, but still afforded unit heads a chance to iron out last minute changes, the need for which became evident only when the plan was put to actual use.

Every meeting and every step of planning were given accurate and adequate coverage by both the press and radio. Advance publicity also included feature stories and spot announcements. The actual demonstration was covered from beginning to end by newspaper reporters and photographers and the radio station did a direct broadcast from the sorting room preceded by a direct broadcast from the scene of the explosion. Out-of-town papers carried photographs and stories the day after the exercise.

We feel that in our disaster program we not only trained personnel in medical procedures, but also did a job of showing the people of the community in which our hospital functions that we are here to help them and are qualified and eager to be of service if the need arises.


NOTE: Raise inner flap before placing papers inside; then fold it down over contents to prevent them from dropping out. Fold outer flap over opening as additional protection.

TRANSPORTATION MEMORANDA

(*In order that the movement of patient from one hospital to another may be recorded chronologically all transportation units transporting patients from one hospital to another should make appropriate entries in the spaces provided below.*)

FROM (HOSPITAL UNIT)	PATIENT WAS TRANSPORTED TO (HOSPITAL UNIT)	BY (TRANSPORTATION ORGANIZATION)	DATE

TO

NOTE: Must be securely attached to patient. To contain individual medical records pertaining to this patient.

LAST NAME FIRST NAME INITIAL E.M. TAG NO.

HOME ADDRESS

HOSPITAL

PRINCIPAL DIAGNOSIS (Brief)

ORDERS FOR IMMEDIATE TREATMENT

- ☐ SURGERY
- ☐ TRANSFUSION
- ☐ SHOCK
- ☐ TOURNIQUET

ADMIT TO

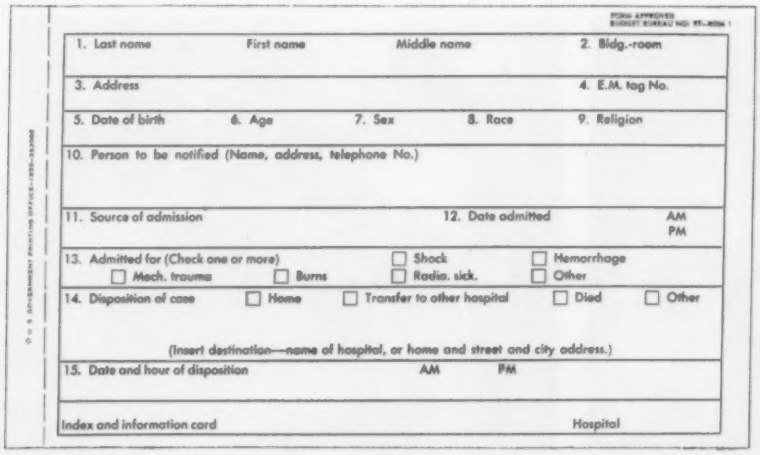
DATE ADMITTED A.M. P.M.

SPECIAL ATTENTION NEEDED IN TRANSIT OR OTHER REMARKS

FINAL DISPOSITION

DATE

Obverse (left) and reverse sides of the casualty tag that was affixed to patients as they were brought into "disaster" receiving and sorting area.


1. Last name First name Middle name 2. Bldg.-room

3. Address 4. E.M. tag No.

5. Date of birth 6. Age 7. Sex 8. Race 9. Religion

10. Person to be notified (Name, address, telephone No.)

11. Source of admission 12. Date admitted AM PM

13. Admitted for (Check one or more)
☐ Mech. trauma ☐ Burns ☐ Shock ☐ Radia. sick. ☐ Hemorrhage ☐ Other

14. Disposition of case ☐ Home ☐ Transfer to other hospital ☐ Died ☐ Other

(Insert destination—name of hospital, or home and street and city address.)

15. Date and hour of disposition AM PM

Index and information card Hospital

Face of the information form made out for each patient. This is made in triplicate. The back (not shown) is used as a supplemental record.

"Brush-Up" Brings Nurses Back to Nursing

Butterworth Hospital is tapping a large reservoir of former nurses who just need refreshing on the newer nursing methods to bring them happily back to work

DONALD E. WALCHENBACH

I'M AFRAID I don't know enough about modern nursing technics," replied the middle-aged woman when asked if she wouldn't like to return to nursing in the hospital.

She is typical of thousands of formerly active nurses throughout the country. Many of them have been out of nursing for several years and have "lost touch." They aren't sure that they could find their way around today's hospital with their former ease and assurance so greatly have hospitals changed in the years that have elapsed since World War II.

Yet almost every hospital in the country could use the skills and talents of these out-of-touch women to immense advantage. And the women themselves often are eager to return to nursing.

Recognizing in them a great resource on which hospitals throughout the state might draw, Butterworth Hospital, Grand Rapids, Mich., last year instituted a refresher course for inactive nurses.

Recently Butterworth "graduated" 248 registered nurses from the refresher course. Most of the 248 had been out of nursing for several years. They came from widely separated communities in western Michigan, and returned to their own towns and cities, at the course's end, to make themselves available to the hospitals in their home communities.

Naturally we at Butterworth Hospital were interested in recruiting more registered nurses for our own staff. But we also realized that making the refresher program accessible to nurses throughout the state would help to ease competition for nurses and would thus indirectly help to relieve our own nurse shortage.

With this in mind, we sent to editors of Michigan newspapers, county clerks, hospital administrators, and civil defense directors an announcement of the refresher course and asked them to cooperate in getting the information to inactive registered nurses.

The letter sent to these officials emphasized the urgent need for informing locally all nurses in the area. It stressed the importance of public health and of being prepared for local emergencies.

The response was more than gratifying—it was overwhelming. On registration day Butterworth Hospital's teaching capacity was oversubscribed by 400 per cent. The original plan was to hold two classes a week for 12 weeks, the classes to meet from 7 p.m. to 9:30 p.m. The unexpectedly large turnout compelled us to alter our plans and to hold parallel classes on alternate evenings, four nights a week, to accommodate the large enrollment.

Every "student" received material which had been previously prepared by the nursing department under supervision of the director of nurses. This kit included a pocketed folder which contained an outline of the course, an outline of Butterworth Hospital's nursing procedures, scratch paper, a general information card, and an identification card with space for the student's name. The card was to be pinned to the student's dress.

The general information card asked for the following data: name, address, school of nursing from which graduated, year of graduation, states in which nurse was registered, and where employed since graduation.

Besides serving the more obvious purposes, this information afforded material for a general study of the inactive nurse. It disclosed, for example, that neither age nor distance was any barrier to organizing refresher courses

Mr. Walchenbach is assistant director of Butterworth Hospital, Grand Rapids, Mich.

The pocketed blue folders contain information about the course, identification cards, and pertinent information for the students. Each student received a folder preceding the first lecture.

of this sort, since there apparently were nurses of all ages happy to brush up on their technics and willing to travel considerable distances for the opportunity to do so.

Applicants ranged in age from 25 to 81. They had been out of nursing for varying lengths of time, up to 26 years. One woman, the mother of teen-aged children, valued the classes so highly that she traveled 360 miles twice a week to bring her nurse's training up to date. In all, 34 Michigan cities and towns were represented in the classes.

The enthusiastic instructors for the course—all of whom contributed their time voluntarily—were members of the school of nursing faculty and nursing service supervisors. The program was divided into two sections. The first section consisted of six lectures on the following topics: (1) newer concepts in medical nursing; (2) newer concepts in surgical nursing; (3) newer drugs; (4) newer concepts in obstetrical nursing; (5) newer concepts in pediatric nursing; (6) other members of the health team, their functions and responsibilities.

The second group of six lectures consisted of demonstration and practice of newer nursing arts technics. This included practical experience such as working in the postoperative recovery room, intravenous therapy and blood, charting, use of newer nursing aids, and so forth.

The purpose of each lecture was to present to the group the best current thinking, information and procedures in each specific field. This was done by resorting to a variety of teaching technics. Panel discussions were held in which instructors and supervisors were used. Skits were presented, demonstrations were made, and lectures were given. Students were required to participate in some of these activities. In each class the instructor provided a printed outline of the lecture to be given. Although the course was given without charge, it was suggested (although not required) that each student purchase a text on medical and surgical nursing, a medical dictionary, and a nursing procedure manual.

Students in the refresher course were made to feel welcome and efforts were exerted to make them feel at home. The "hello cards" on which they had written their names proved invaluable aids in helping the students to get acquainted with one another. And a mid-session coffee break in the hospital dining room served further to dissipate uneasiness and establish warm, friendly relations.

A special effort was made to keep each student's personal expense at a minimum by organizing car pools for those who came from neighboring towns and cities. Each student was issued a hospital employe's parking permit, which helped to eliminate the parking problems that usually confront visitors to a hospital in the downtown area. As a result, the students felt that they really "belonged" and that they were not an extra burden on the hospital.

In preparation for a second refresher course, we asked the students to complete a "refresher course evaluation sheet" at the conclusion of the final lecture. These sheets proved both encouraging and instructive.

From them, we learned that the course had come up to the students' expectations and that the sessions on new drugs and the administering of new medications were considered the most valuable. Asked what additional subjects they would prefer to have had presented, a majority of the students cited polio, psychiatry and operating room technics.

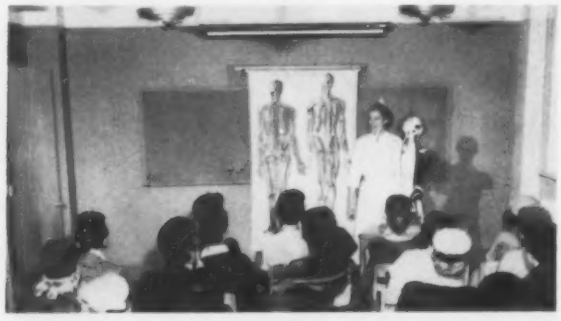
If the students' reaction had ended there, the course would have had to be viewed as a somewhat dubious venture. But it didn't end there. Actually it had exactly the effect desired. It encouraged the inactive nurses to become active again. Most of them indicated on their questionnaires that the course had revived their interest in nursing and that it had equipped them to be of greater service to their individual communities. Many of them were frank to admit, also, that the course had restored their confidence and had enabled them to resume nursing careers in their respective communities.

Butterworth Hospital itself had dramatic proof of the effectiveness of the nurses' refresher course. Immediately on completing the course, 12 of the R.N.'s who had enrolled applied and were accepted for employment on Butterworth's staff. Moreover, 25 others disclosed that they wished to join the hospital's nursing staff in the fall. Many hospitals throughout the state also have enthusiastically reported sudden and welcome additions to their nursing staffs from among the erstwhile "students" of the refresher course.

Perhaps most indicative of the way the "students" felt about their brush-up training was the final gesture made by both classes. Acting strictly on their own, they took up a sizable collection and presented it to the director of nurses to be used at her discretion for the nursing department.

Assured that next year's courses will be expanded to cover some of the fields which of necessity had to be overlooked this first year, many of the "graduates" have declared their intention of coming back for a "post-post-graduate" course. The second "semester" will begin April 8, with a virtually full enrollment already guaranteed. All of which leads officials at Butterworth Hospital to conclude that it's folly to give inactive R.N.'s the brush-off. Give them a brush-up!

Instructors of the Butterworth Hospital School of Nursing contributed their time to teach new technics of patient care.



It's been a long time since anatomy classdays. The refresher course brought back memories as well as basic skills.

With the skeleton beaming approval in the background, Dr. Irving Goodof lectures his amateur physicians and surgeons at the Sunday morning medical seminar at Thayer Hospital.

Laymen Spread the Gospel of Health

This informal course for a group of medically-minded laymen who call themselves SAPS is a useful means of creating understanding between community and hospital

PAUL W. STERNLOF and GEORGE T. NILSON

AT THE Thayer Hospital in Waterville, Maine, the term SAPS stands for the "Society of Amateur Physicians and Surgeons." This society is made up of "students" in an intensive course of instruction given by the medical staff of the hospital. These individuals are laymen from the community who are interested in learning more about the human body in health and illness. The 15 man group meets weekly at the hospital at the only time when it is possible for all of them to come together, Sunday mornings from 9 to 11 a.m., to participate in a seminar on some aspect of medicine and health. The aim of the program is not to attempt to train junior physicians but to give a selected group of lay people a better understanding of medical and hospital affairs.

SAPS is the brainchild of Whitcomb Rummel, a local ice cream manufacturer and member of the advisory board of the hospital's Mansfield Clinic, and Dr. Irving Goodof, the pathologist. Both men had strong convictions that some facility should be available whereby laymen could learn more about the field of medicine, and together outlined the program that was to become SAPS. Very quickly 15 local men, most of whom had no particular identification with the hospital, were recruited.

In the earliest sessions Dr. Goodof gave the group fundamental general concepts. He presented the rudiments of anatomy and physiology, proceeding from cell structure to organs, to organ systems, and then to disease mechanisms and disease entities.

After the basic groundwork on human biology was laid, the group proceeded to discussions on various medical specialties. On these occasions other physicians were brought into the program. For example, an internist discussed cardiology and a psychiatrist talked on his specialty. After the organization had been in operation for some time and the "students" had received a general orientation, they were able to observe actual necropsies in the hospital's morgue. This served a double purpose, enabling the pathologist to demonstrate the value of necropsy and providing a means of relating what had been discussed relative to various disease processes to what could be observed at necropsy.

The group has learned about many of the hospital's special services and departments. The members know something of the myriad functions and tests the clinical laboratory is called upon to perform. They know how x-ray studies, deep therapy and radioactive isotopes can aid in the diagnosis and treatment of disease. They have learned about biopsies and the value of the frozen section. They know how mechanisms such as the tissue committee and medical audit, by which the physicians evaluate their performance, operate. They have learned why consultations are often necessary and why the medical record is important.

Members of the group come from all walks and callings of life. A radio

Mr. Sternlof is administrative resident, Thayer Hospital, Waterville, Maine, and Mr. Nilson is the health educator with the Bingham Associates Program assigned to the state of Maine.

station executive, the local superintendent of schools, the district attorney, a chemist and a private investigator are among the men whose occupations are represented. What these men have in common is deep intellectual curiosity and a keen desire to know more about medicine and health. Whether we like it or not, and we should like it, the medical and hospital fields are tremendously interesting to the general public. The group feels that its organization is satisfying this interest and directing it into constructive channels.

What has all this accomplished in terms of better community health? In the first place, a common criticism of programs of this sort is that, in essence, a little learning is a dangerous thing. It is sometimes feared that the layman, exposed to such material, will tend to develop hypochondria or, worse still, engage in self-diagnosis and treatment.

This particular experience would refute that argument. All of the members of the group are unanimous in their feeling that an intelligent understanding of disease is healthier than the anxiety that is a product of ignorance. Also, the one general principle they all feel they have learned is that illness, its diagnosis and treatment, is something that must be left to the specialist, the physician. They have gained an appreciation of the complex that is the art and science of medicine and realize their own inadequacies.

On the positive side, they have learned the value of the periodic health examination and of the need for early diagnosis and prompt medical treatment. They have become disciples of the gospel of these principles. As a small example, one of the men told how, on his vacation, he had persuaded at least five relatives and friends to obtain complete physical examinations. These are men who are respected in their community and whose voices are heard by those with whom they come in contact.

The physician-adviser of the program feels that there is being developed in the community a nucleus of medically aware citizens who are in a position to reach numbers of people with a positive health message. This is a group, he believes, that can be counted on in any medical emergency, whether it occurs in the home or in the community at large, to keep its head and prevent hysteria. Also, a group of "friends of the hospital" is being formed, a group to which the hospital looks for support.

As Dr. Goodof says, "I have always had the desire to determine if it would be possible to give a group of mature, intelligent laymen an honest and straightforward orientation in medicine and have them accept the same in a healthy, responsible manner. My experience with this program has convinced me that this can be done."

The hospital, in a quite practical way, has benefited by the program. Its public relations value is incalculable. The men have got to know the hospital and have been able to observe the physical and organizational structure that characterizes the modern hospital of today. They are proud of "their" hospital and the kind of service it offers the community. They have a real appreciation of the whys of hospital costs and are in a position to clear up some of the misconceptions regarding hospital costs much more effectively than anyone directly connected with the hospital could.

Also, these men are among the leading citizens of the community and as such might be logical future trustees. How much more effectively a person with such an orientation could function in the rôle of the trustee!

More important, however, a group of citizens is using the hospital and its facilities to learn how they and their families can orient themselves toward the achievement of healthy, productive lives.

Everett Jones Retires From Publishing Company; Will Continue as Consultant


Everett W. Jones

CHICAGO.—Everett W. Jones, vice president of The Modern Hospital Publishing Company since 1942 and publisher of the *Hospital Purchasing File*, will retire from active, full-time service at the company's offices here February 1, but will continue to serve as technical adviser to the editorial staff of The MODERN HOSPITAL.

In addition to his work as a consultant to The MODERN HOSPITAL, Mr. Jones will also do planning and administrative consulting for hospitals and hospital communities.

Starting this month, Mr. and Mrs. Jones will make their home at Fort Myers Beach, Fla., but they expect to spend a few months each year in Waukesha, Wis., where their son, Robert M. Jones, is administrator of the Waukesha Memorial Hospital.

Mr. Jones had planned to give up his full-time duties with The Modern Hospital Publishing Company and move to Florida a few weeks earlier, but his plans were delayed by an illness requiring surgery in Chicago. For the last month, he has been back at his office here preparing for the move.

Mr. Jones joined the staff of The Modern Hospital Publishing Company in 1942 following two years of service as hospital consultant to the War Production Board. In this capacity, he traveled extensively all over the United States, visiting hospitals to determine needs and priorities for materials in short supply.

Prior to his service with the War Production Board, Mr. Jones was for ten years administrator of the Albany Hospital, Albany, N.Y. An engineer by training, Mr. Jones was graduated from the University of Wisconsin and was chief engineer and operating superintendent of the John A. Manning Paper Mills, Inc., of Troy, N.Y., for several years before going to the Albany Hospital.

Throughout his career in the hospital field, Mr. Jones has been active as a speaker, lecturer and discussion leader at hospital association meetings. He has also been associate director of the Program in Hospital Administration at Northwestern University and has lectured and taught classes in hospital administration at other universities and at numerous institutes. He is a fellow of the American College of Hospital Administrators and has written articles on all phases of hospital administration.

"Mr. Jones' great contribution to hospitals is well known to hospital people everywhere," said Raymond P. Sloan, chairman of the board of directors of The Modern Hospital Publishing Company. "His many friends in the hospital field, including all of us at The MODERN HOSPITAL, will welcome the news that he is going to continue serving hospitals as a consultant, and as technical adviser to the editors of The MODERN HOSPITAL."

They Learn to Supervise by Supervising

When it comes to teaching supervisory skills, this hospital recommends the conference method since most adults learn better by participation and practice than they do by being lectured at

E. J. O'MEARA

IN A previous article, supervisory training was shown to be an important factor in the effective administration of a modern hospital. The objectives of such training as well as course content were discussed.

In this section, the who, what and how will be defined. At Altoona Hospital, Altoona, Pa., the problem of who should conduct a supervisory training program received a great deal of attention. Should we arrange for courses by experienced educators from near-by Pennsylvania State University, should we seek assistance in the way of trainees from local industry, or should we do it ourselves?

It was decided that we should do it ourselves, for this reason: It is generally recognized that adults are taught least effectively by lectures and most effectively by participation.

WANTED TO LEARN SKILLS

What our supervisors wanted to learn more than anything else were *skills*, which could only be learned by practice and participation. Consequently, it was felt that a person from the hospital, knowing and understanding the participants and their problems, would stand the best chance of obtaining the active participation of the conferees. This reasoning proved correct, and we are satisfied that we obtained results that a person from outside the hospital family could not have achieved.

What methods should be used to teach these adults, each with extensive education and experience of his own? Basically, the conference method was used throughout, with variations and other technics used as indicated. It was mutually understood from the first meeting that the sessions were essentially an exchange of ideas and experiences of the conferees.

The idea that 10 participants may represent a combined total of 100 years' supervisory experience makes a conference leader think twice before proceeding with a lecture approach. Thus, we can see that the conference leader is the stimulator of ideas, the guide to keep discussion in pertinent channels, and the one responsible for summarizing the group's ideas.

Many technics have proved successful when used in conjunction with the conference method. One that we used to advantage was the case study method. Case studies stimulate thinking, pro and con, about problems, and easily focus the group's attention on particular phases of management. A case study is a description of a problem which points up all of the important factors involved in the situation. It is then up to the conferees to discuss the problem, emphasizing causes and effects as well as practical solutions. Case studies can be taken from one's own experiences or can be taken from source books. It is important to relate the case studies to the hospital situation as closely as possible, as cases dealing with manufacturing situations will not hold much meaning for the group.

An example of a case study that we used stated that you, the supervisor, received a phone call from the wife of one of your employes. She requested that you not allow him to work overtime because he uses this as an excuse for coming home late at night. You have noticed that his production has fallen off lately, and there are indications of dissipation. You need your men to work overtime because you are behind schedule.

GROUP ANSWERS QUESTIONS

After the case is read, it is discussed by the group. These questions were asked of the participants: What should you say to the man's wife? How should you handle the dissipation angle? What effect will your actions have on the morale of the rest of the group? Should you ignore the whole situation? To what extent are you your brother's keeper?

It may be of interest that our group felt very strongly that the supervisor's limit of responsibility lay in the dissipation angle. That is, if the worker's level of production could be restored satisfactorily, one might be asking for trouble to excuse the worker from overtime or to interfere with what appears to be a domestic problem.

An example of how our conferees participated in the conferences is shown in our sessions on "How to Instruct the New Employe." An hour

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Mr. O'Meara is assistant superintendent of Altoona Hospital, Altoona, Pa.

This is the second of two articles by Mr. O'Meara on supervisory training. The first appeared in the January issue.

was spent in demonstration of poor and good instruction technics, with the conference leader as "teacher" and the conferees as "pupils." Each conferee was then asked to bring to the next session a teaching situation from his department, or from his hobby. Each conferee taught a second conferee, while a third acted as evaluator, to see if the teacher used proper and effective technics.

Can you imagine our dietitian, weighing all of 100 pounds, learning how to field strip a 9mm. German Luger, or our assistant business manager (male) learning how to knit? Seems ridiculous? What could demand better teaching technic? Our business manager learned how to make a paper bedside waste bag, and our director of nursing service learned how to accrue a monthly payroll. Several other examples gave each conferee the opportunity to practice this skill of teaching with friendly assistance.

TEACHER WAS CRITICIZED

Following each presentation, the evaluator criticized the teacher. Did she break down the steps of the operation? Did she stress key points? Did she properly prepare the worker, putting her at ease and creating interest? Did she properly present the job, demonstrating it slowly? Did she have the learner perform and correct her mistake? Did she arrange for follow-up? This type of free criticism will only come with the nonstilted atmosphere of the informal conference.

Movies and filmstrips are available, but should be used with caution. Review by the conference leader is essential, as a movie not suited to the needs of the group will result in loss of interest.

We used skits with a great deal of success. In one case, two conferees recorded on a tape recorder in advance of the meeting.

The first part demonstrated poor methods of employe induction. A discussion by the entire group followed this section. Then the recorded skit of good induction methods was played with a conference following. In another "live" skit, several conferees acted out parts to demonstrate poor human relations technics. Again, discussion followed.

One of the most effective methods used was "rôle playing." This is most applicable in discussing human relations problems, and should only be used after the group has met several times and the members have good rapport with each other. The following is a description of one situation where we used this technic effectively.

A problem of employe absenteeism was set up with the supervisor's side of the story on the top half of the sheet and the worker's side of the story on the lower half. All participants but two were given both sides of the problem and asked to analyze the problem. What are the causes and effects? What are the important factors involved? What is a good practical solution? The remaining two participants were each given one-half of the sheet, one getting the supervisor's side of the story and the other the worker's side of the story. They were asked to act out these parts in a corrective interview between the supervisor and worker. The group had the advantage of having the insight to see what happens when two people come together in a corrective interview, each knowing only his side of the story (which happens every day). The group saw the problem unfold and a solution reached. A discussion was then held by the entire group as to the supervisor's technics, whether he obtained the information, and whether they agreed with his solution. The entire group was intensely interested and felt that this technic was extremely beneficial.

VISUAL AIDS ARE USEFUL

Visual aids were used in every conference. A blackboard was constantly available to write summaries, definitions and outlines of ideas to assist the group. An opaque projector was used to show charts, graphs, pictures and diagrams, either to stimulate discussion or summarize ideas.

In conducting the program, I investigated several sources of information. The following resource materials may be of benefit to hospital administrators who wish to establish a program.

From the U.S. Government Printing Office, superintendent of documents, a "package program" may be obtained for a nominal fee. It was designed for use by the air force in teaching supervision to military and civilian personnel. It consists of 25 booklets, each designed to cover a conference on a certain phase of supervision, as "How to Plan," or "How to Induct the New Worker." The booklets contain several brief case studies, as well as skits, some of which are applicable to hospitals. I found some of the information quite valuable. The exact title is "Management Course for Air Force Supervisors," AFP 50-2-1 through AFP 50-2-25.

Another package program for supervisors has been developed by the Mutual Benefit Life Insurance Company, Newark, N.J. It is designed to be taught by you, using guides that the company furnishes free of charge. The films from this program also are available from the American Hospital Association film library. It consists of 10 one-hour sessions and includes films and film sequences furnished free. A detailed conference leader's manual is available. The topics covered include teamwork, planning, integrity, craftsmanship, leadership, communications and management skills.

GOOD TEXT ON MANAGEMENT

Another source which we found particularly useful in our program was a text entitled "Management Training" by William J. McLarney. The book deals in principles and case studies. The case studies are brief and are followed by searching questions about the cases. These served as bases for lengthy discussions. A "Conference Leader's Manual" is also available from the same publisher, Richard D. Irwin, Homewood, Ill., which was written for use in conjunction with "Management Training." It contains suggested questions which may be used to stimulate the group's thinking.

Rôle playing situations are available commercially. We located an adequate supply from Mr. McLarney, San Jose State College, San Jose, Calif.

It is hoped that any of the foregoing material may help hospital administrators seeking to establish supervisory training programs to meet their own particular needs.

We in Altoona feel that the investment in time and effort has paid off in improved patient care and it is our intention to continue the program as standard policy of the hospital. Having conducted the program ourselves, we are in an advantageous position to follow up with individual participants as a matter of routine. The application to the hospital situation of the course content is the pay-off of the entire program. We are also continually seeking evaluations of the program from the participants so that succeeding years should see better and better programs.

Mechanization Gives the Right Answers to Small Hospital Accounting Problems

DAVID J. WIRES

ACCOUNTING in a small hospital is the same as accounting in a large hospital. Then why is it that, generally speaking, large hospitals have good accounting and small hospitals have something vaguely resembling it? Personal observation and study of this problem indicate that there are three principal differences.

1. Board members of large hospitals are often connected with large corporations and are aware of the necessity for good accounting. They speak of it in the larger sense, that is, not only complete, accurate and prompt financial accounting, but statistics, costs and all data that should be available to a person charged with the responsibility of administering any organization.

2. The large hospital has better bookkeeping personnel and a better accounting department organization. This is because the larger problems and larger volume demand the services of more skilled, better educated, and more experienced individuals who can direct the efforts of the many less skilled employes in the department. This second reason is related to the first in that the board of the large hospital will bid for the services of such skilled individuals. The small hospital often feels it cannot compete against the commercial accounting salary scale for such persons.

3. The third reason is directly related to both the foregoing. The large hospital provides the best office machinery, facilities and working space possible. The administrator, the board and the skilled accountant know that necessary and proper records cannot be turned out in the quill-pen, roll-top-desk atmosphere still prevalent in many of our smaller hospitals.

This is, of necessity, a personal narrative. In my previous hospital experience I was too often in the position, or saw the administrator in the position, of being unable to deal with a situation because of lack of necessary data. And I was determined, on coming to Galion Community Hospital, that this situation would not be continued. The following relates some of the things we did and some of the things we are doing to get "big hospital" accounting into our 70 bed institution.

Item No. 1 was the board—which turned out to be no problem at all. The board of our hospital has on it men in manufacturing and commercial concerns which, while they do not compare to the giants, increasingly operate on a nationwide and even worldwide scale. There was no need to convince the trustees of the value of good accounting. There was only the need to show them why we should have it in the hospital. They were shown nothing new or startling. With income

Mr. Wires is administrator of Galion Community Hospital, Galion, Ohio.

All of the bookkeeping routine at Galion Community Hospital has been mechanized by the use of a single, versatile typewriter-bookkeeping machine.

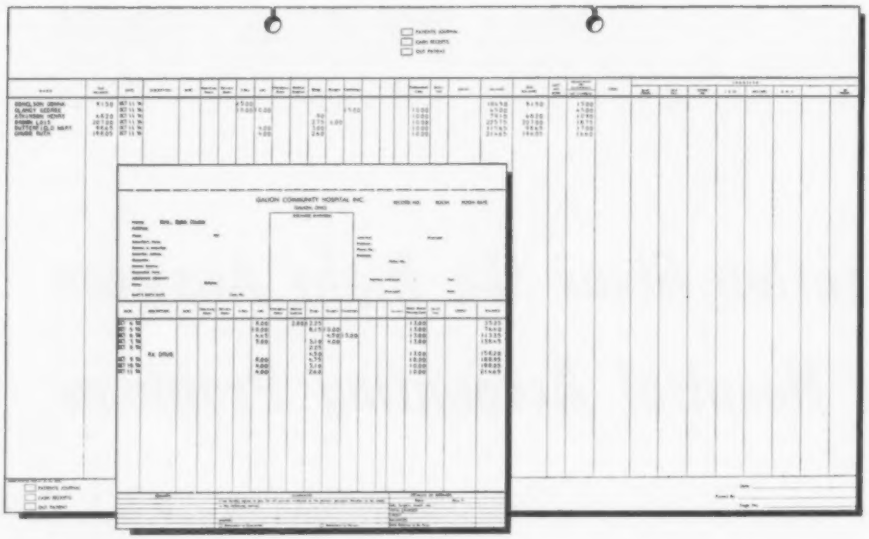


Fig. 1. As patient's statement-ledger card is posted, the patient's journal is also printed. Charges are put in individual columns, which accumulate in separate totals for the over-all posting.

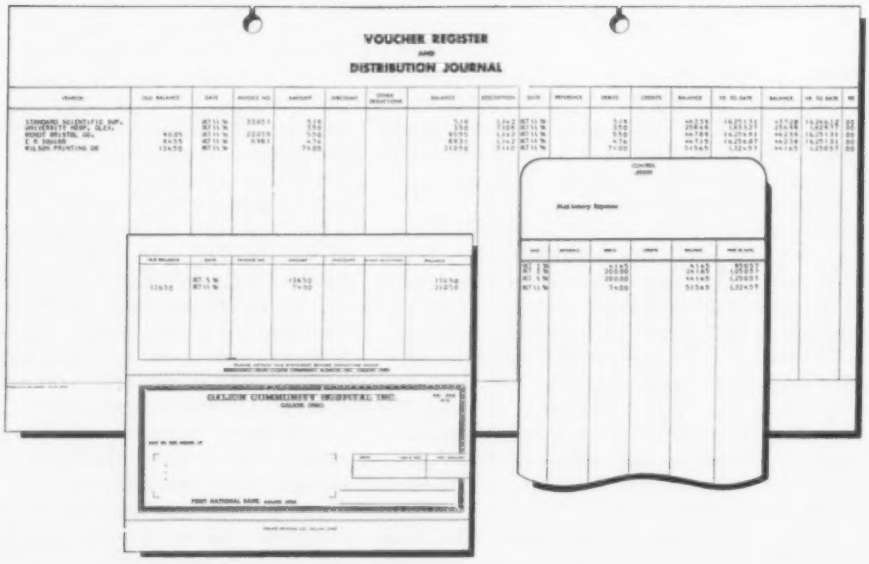


Fig. 2. Accounts payable setup. Voucher-remittance advice is posted at left, and distribution is made directly to individual ledger cards at right. Note "00" proof of posting in the right-hand column.

and expenses of more than $300,000 annually, we were one of the larger institutions in our small city. We had a number of situations and conditions to be dealt with immediately, and we did not have the necessary data to handle them properly. It was as simple as that. When the board members looked at it from that angle, they did not have to look twice. They told me to put in the best accounting we could afford.

We felt that the answer to the problems of our bookkeeping system could be found only by devising a complete machine accounting system for our hospital, a system that would provide all the information needed, on an up-to-the-minute basis, without increasing personnel. With this end in view, we worked closely with the accounting specialist for the Ohio Hospital Association in the design of our present mechanized procedures. At the time the machine was purchased, there were no funds available, but we felt the equipment was important enough to commit ourselves despite this fact. After 12 months of operation, we now have a system of which the following are some of the principal terms.

CHARGING PATIENTS' ACCOUNTS

Our charges run from midnight to midnight. All charges are written up on the same type of slip, and at the same time a charge control journal is prepared automatically by means of a carbon paper. Each department has its own distinctively colored slips. Pricing of the charge slips (other than for drugs) in the nursing area is done by the night group, and the slips must be turned in by 7 a.m. Other departments price their own slips and turn them all in by 7 a.m. Drug prices on all slips are entered by the accounting department, first thing in the morning. Also, the census is checked and any rate change is noted on the patient's ledger card. The daily machine posting of these accumulated and sorted charges is made on the patients' ledger cards each morning. The room rate is noted at the top of each patient's statement-ledger card. Figure 1 shows the exact procedure. The old balance on the patient's account is "picked up," charges are posted in the

appropriate columns, and the new balance is automatically computed and printed by the machine. All postings print through to a patient's journal beneath.

As each account is posted, the individual columns accumulate in separate totals within the machine. In the case of unannounced discharges, late charges, errors or forgotten charges omitted in posting, the patient's ledger card is immediately reinserted in the machine and the corrected or additional figures are posted to the card.

In posting, no specific order need be followed. If a patient is checking out, his account, including any late charges, can be posted immediately. Any cash paid when he leaves can be entered at the same time; if an account is to be transferred to another control, it is done immediately on the patient's journal.

When all postings are finished, the totals are cleared out and posted to individual income cards once a day. The over-all total of accounts receivable charges, also yielded by the machine, must be proved against a recap of the handwritten charge control journals mentioned before. This over-all total is then posted to the accounts receivable control, inpatients' accounts. The actual date of charges is used as the posting date. In the event of late charges, discharges or corrections, the actual date of posting is used. A new journal is used for each day's postings.

A separate set of income account ledgers and a separate accounts receivable control card are maintained for outpatient charges. For all outpatient charge accounts and industrial commission (workmen's compensation) cases, charges are posted to individual patient ledger account cards. There are four other accounts receivable controls: Blue Cross, self-pay (including all other insurance companies), industrial (or workmen's compensation) and welfare (including all government agencies). However, these are not affected by the daily charge posting. At the time a patient leaves, his account will be transferred to one of these controls. For all cash outpatient accounts, charges are posted on one ledger account card.

In examining the patient's statement and ledger card in Figure 1, observe that all miscellaneous charges are coded on the machine. An explanation of the code is given at the bottom of the patient's statement, which is actually a carbon copy of the ledger.

Thus, this system enables us to give the patient an up-to-date, accurate statement of his account *before he leaves the hospital.* This not only builds good public relations, but is an important factor in reducing the collection problem as well.

The statement-ledger forms are made up in duplicate copies as they have been fully approved by the Central Hospital Service of Columbus (Blue Cross) and by other insurance agencies as well. One copy is sent directly to them without being transferred to any other forms.

Fig. 3. The check register is produced as a by-product of writing checks, a job that is done on the typewriter-bookkeeping machine.

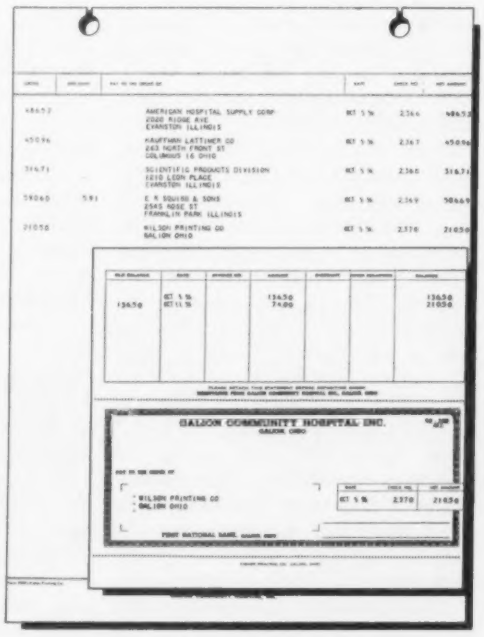
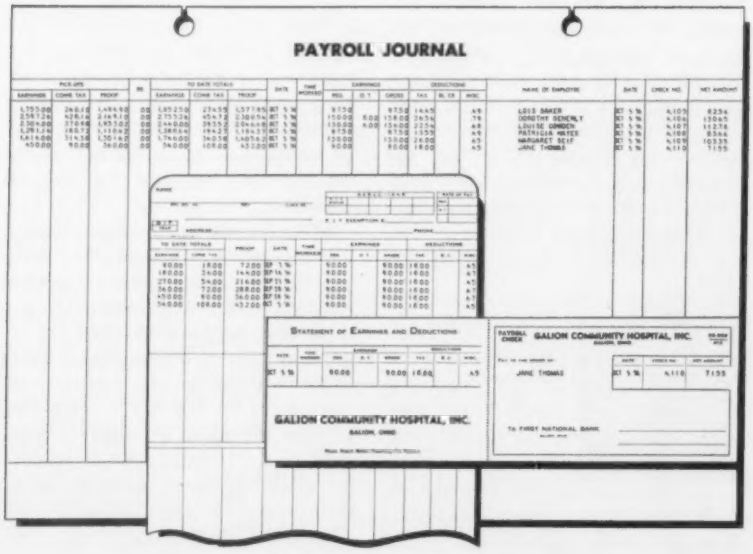


Fig. 4. Payroll writing combines all records in a one-shot operation: employe's pay statement, check, earnings record, check register, and payroll journal. To-date totals for earnings and combined tax are also automatically computed.



CASH RECEIPTS

At present, we write hand receipts for cash payments. As each receipt is written, spot carbon automatically prints the patient's name and the amount received on a cashier's daily report. Receipts are segregated on this report form in columns, according to the control affected (self-pay, Blue Cross, industrial welfare or outpatient). We are planning to replace this system with a remittance control

machine as soon as it is financially possible. Such a machine will mechanically print a receipt and at the same time lock the amount into the proper total. The operation will consist merely of setting up the amount on a keyboard and touching a control button. This will instantaneously cause validation of the receipt, addition to the correct control, and recording of the transaction on a journal tape locked inside the machine.

At present, though, the cashier's daily report is used as a basis for posting cash receipts to patients' accounts. This consists simply of picking up the old balance on a patient's account and posting the amount paid; the machine automatically figures and prints the new balance. The over-all cash total accumulates and proves against the cashier's daily report. (The cash receipts journal is exactly the same form as the patient's journal.)

It has been shown that all income is classified. Statements and ledgers are machine-posted daily. The distribution to income ledger cards, the control ledger cards, and the journals are also posted daily by the machine. Therefore, the accounts receivable and income ledgers must balance each day with the proof totals from the machine postings. A trial balance can be run any day of the week since all records are posted to date daily. We shall see now, from the accounts payable end, how expenses and inventory also are finely segregated and maintained with positive accuracy.

ACCOUNTS PAYABLE

The accounts payable setup is pictured in Figure 2. This job is done twice a week. Directly from vendors' invoices, amounts are vouchered at the left; distribution is then made immediately to an expense or inventory card at the right. Department expenses are posted directly to department expense cards. The machine computes and prints the voucher balance, and both the month-to-date and year-to-date balances on the expense or inventory ledger card. The "00" proof in the extreme right-hand column indicates that old balances were picked up correctly, and that the amount vouchered was equal to the amount distributed.

Checks are also written on the same machine. A check voucher form is used. Following the end of the month or at any time, the check to the vendor may be written on the machine from the accumulated information on the upper or voucher portion of the check form. A check register is an automatic by-product of this operation.

Some expenses are distributed directly to departments but most supply items are distributed to an inventory account. Hospital departments procure their supplies only by requisitioning. These requisitions are then extended and machine-posted as charges to the various departments. They are automatically accumulated and relieved, at cost, from inventory.

At the end of the month, therefore, we know exactly what our net earnings are, by department as well as for the hospital as a whole. Our profit and loss, balance sheet, and earnings statement are run off much sooner than if these figures had not been accumulated throughout the month. Such information gives me, as administrator, control of finances; by knowing exactly what our earnings and daily cash balance are, we know how far we can go in making expenditures. It also gives financial control over the hospital, through departmental expense and earnings figures. Anything "out of line" quickly comes to light. For instance, we now know our ratio of income to expense for each department, and by watching the cumulative figures for both during the month we are able to detect discrepancies in time to do something about them, instead of merely regretting a failure long after the close of the month.

Individual time cards are kept daily by departmental supervisors. At the end of the month (or end of the pay period) the total time worked, adjusted by approved overtime, sick leave or vacation time, is figured by the payroll clerk, the individual employe's payroll journal card being used. Payroll deductions including withholding tax, city income tax, F.I.C.A. and hospitalization insurance are also computed. These earnings and deductions are picked up by the machine in writing the payroll voucher and payroll check.

PAYROLL RECORDS

The following payroll records are posted simultaneously: the check register and journal, the employe's earnings card, the pay statement (voucher), and the check.

The gross earnings to date and tax deductions to date are figured automatically by the machine and printed on the earnings card. Therefore, the quarterly reports and income tax forms are prepared without any further adding of figures to determine quarterly and yearly earnings by the employe.

The machine automatically accumulates totals for gross pay, net pay, F.I.C.A, and withheld tax, insurance and city tax by department, thus providing the basis for distributing labor costs to the various departments. These machine postings are, of course, entirely separate from the accounts payable operation.

The mechanized system makes possible an accurate daily report of cash on hand and in the bank, accounts receivable by control classification, income (also classified), and expenses. On both the daily and monthly statements, the figures for the year to date are also given; these are simply copied from the ledger cards.

It may be well to mention that the entire general ledger is also kept, by machine, on cards similar to those shown in Figures 2 and 4. This information is vital to efficient operation. Mechanization, we believe, is the only answer; it is even more important to a small hospital than to a large one. Only by this means can the small hospital administrator get the figures he needs in time to do something about them.

An analysis of income and expenses is almost automatic with our present plan of operation. Equally important, all figures are up to date at all times, and *in proof,* in a manner inconceivable under pen-and-ink methods. The entire bookkeeping job has been simplified. It takes no unusual talent or training to run the machine. As with all classes of personnel, there are good machine operators or mediocre operators. Alertness and adaptability are the prime requisites for this type of work. Since everything goes through the machine, a good operator is the one who puts the right data into the machine.

Now, the entire hospital's finances are on a satisfactory basis. This is the sort of thing that can be accomplished when accurate cost and income figures are available, right after they occur.

All of this is being done without increased personnel and *without overtime* of any kind, and it is being done without the need of highly trained, specialized personnel. In our opinion, the system provides the long sought-for "answer" to the accounting problems in a small hospital.

Administrators


Dale A. Smith

Dale A. Smith has been appointed administrator of Sister Kenny Memorial Hospital and Rehabilitation Center, El Monte, Calif. Mr. Smith is a graduate of Brigham Young University and is a member of the American Association of Hospital Accountants and the American Accounting Association. He formerly was business manager of Utah State Hospital, Provo.

Terry Hiers Jr. has been appointed administrator of Americus and Sumter County Hospital, Americus, Ga., succeeding **George E. Linney,** whose resignation was announced in the December issue of The Modern Hospital. Mr. Hiers formerly was assistant administrator at Baptist Hospital, Nashville, Tenn.


Arnold Mouish

Arnold Mouish has been named assistant manager of the Veterans Administration Hospital in Newington, Conn. Since July 1956, Mr. Mouish has been special assistant to the manager of the Veterans Administration Hospital, Northport, N.Y. Mr. Mouish is is a graduate of the program in hospital administration at Northwestern university.

John G. Dudley has been named executive director of Memorial Hospital, Houston, Tex., and **W. Wilson Turner** has been promoted to the position of administrator. Mr. Dudley, the former administrator, now is chief administrative officer and coordinator of the hospital and the 15 story medical professional building under construction adjacent to the hospital. Mr. Turner formerly was associate administrator at the hospital.

Ronald D. Burton has been appointed administrative assistant and night administrator at University Hospital, Birmingham, Ala. He succeeds **Edward G. Hertfelder,** whose appointment as director of outpatient and emergency clinic services at the hospital was announced in the January issue of The Modern Hospital. Mr. Burton formerly was administrator of Our Community Hospital, Scotland Neck, N.C.

G. Dale Splitstone has been named assistant administrator at Reid Memorial Hospital, Richmond, Ind. Mr. Splitstone received his master's degree in hospital administration from Columbia University. He served his administrative residency at Colorado General Hospital, Denver, where he also served two years as assistant administrator.

George T. Brotherton has been named administrator of John Peter Smith Hospital, Fort Worth, Tex.

Judson F. Marsters resigned his post as administrator of Southern Pacific Hospital, Houston, Tex., to become administrator of Spohn Hospital, Corpus Christi, Tex.

Arthur G. Turner has accepted the position of administrator of Whittier Community Hospital, which is under construction in Whittier, Calif. He has been administrator at Kaiser Foundation Hospital, Fontana, Calif.

Andrew W. Saphiloff, administrator of John Graves Ford Memorial Hospital, Georgetown, Ky., has resigned the position to become administrative services director of the state mental hospital at Petersburg, Va. Mr. Saphiloff has been in the hospital field more than 15 years and holds a master's degree in hospital administration from Northwestern University.

David W. Morgan is the new administrator at Dow Hospital, Freeport, Tex. He formerly was administrator of Chilton County Hospital, Clanton, Ala. Mr. Morgan has a master's degree in hospital administration from Northwestern University. He is a nominee of the American College of Hospital Administrators.


W. L. Loving

William L. Loving, former administrative assistant at City Hospital, Cleveland, has been appointed director of work simplification at the hospital. He is a graduate of the University of Chicago program in hospital administration. **Henry Veldman** succeeds Mr. Loving as an administrative assistant. Also a graduate of the University of Chicago hospital administration course, istrative resident at Cleveland City Hospital.

Dennison L. Larson, administrator of Schoolcraft Memorial Hospital, Manistique, Mich., has accepted the position of administrator of Bethesda Hospital, Hornell, N.Y. President of the Hospital Council of the Upper Peninsula of Michigan, Mr. Larson is a graduate of the State University of Iowa program in hospital administration.


Alvin J. Conway

Alvin J. Conway has been appointed assistant executive director of Knickerbocker Hospital, New York. Mr. Conway formerly was administrative assistant at Roosevelt Hospital, New York. He is a graduate of the program in hospital administration at Columbia University.


Lt. T. K. Robinette

Lt. Tasker K. Robinette has been named adjutant of the United States Air Force Hospital, Fairchild Air Force Base, Wash. He succeeds **Lt. Frank N. Mollick,** who resigned the position to accept an appointment as hospital administrator with the Arabian American Oil Co. hospital system in Teheran, Iran. Lt. Robinette holds a degree in hospital administration from Washington University, St. Louis.

Alvin Langehaug, a hospital administrator in Minnesota and Wisconsin for more than 25 years, has been appointed assistant general manager of the Lutheran Hospital Society of Southern California. For the last year Mr. Langehaug, a fellow of the American College of Hospital Administrators, has been a hospital consultant to the institutional furnishings division of Marshall Field & Company.

(*Continued on Page* 158)

Where Volunteers Fit Into the Program

To be completely successful, the volunteer service must function as a regular department and volunteers must be carefully integrated with the hospital staff

MARK BERKE

TODAY'S hospital volunteer, if she is good, is by comparison to the volunteer of the 1930's, a professional, trained and skilled in her duties. Yet in this very professionalism lies some danger. Too many hospitals have encouraged the development of volunteer services in the hope that payroll savings would be effected, and I can think of nothing that would make it more difficult, if not impossible, to integrate volunteers into the hospital than such a philosophy. The basic premise must always be that the volunteer is not used to save on the payroll, but instead to render such auxiliary services as the hospital cannot supply.

BRING WARMTH TO HOSPITAL

Many a hospital would be a cold, drab place without the warmth and love that volunteers bring to it, and in some institutions the volunteer can act as a conscience for the paid employe. It is not surprising that, with the shortage of skilled personnel and with many problems to cope with daily, the paid employe forgets, or cannot be bothered with, the personal relationship that should exist with a worried and sick patient in need of reassurance and security. Volunteers, by their very presence, remind paid employes that the needs of the patient and the day-to-day work in meeting those needs are different from the obligations placed on the factory worker or office employe. The volunteer, by her satisfaction in personal service without thought of material compensation, continually reminds us that ours is not a commercial institution but rather a service center whose performance must transcend normal business relations if we are to fulfill our ideals in the care of the sick.

In view of all this, it is most important that volunteer services be nurtured and that they be well integrated with the hospital, and I expect that the most important jumping-off point is the hospital administrator himself. Even though trite, it is nonetheless true that the administrator must really believe in the value and importance of the volunteer to the hospital program. Lip service is not enough. The program will not be completely successful unless the administrator is willing to determine thoughtfully the hospital's needs for volunteers and give as much time and effort to the creation of a volunteer organization as he would to the establishing of a nursing or dietary department.

With the many demands on their time, some administrators will not be willing to give so much of their energy to a service that is as filled with intangibles as a volunteer program. This, of course, is entirely the privilege of the administrator. He should, however, realize that lack of time and energy on his part in themselves assure that the development of a volunteer program will not meet with complete success, and he should govern himself accordingly.

Assuming the administrator is willing to give sufficiently of himself, he must also recognize that his newly created service is an integral part of the hospital organization, equally as important as any other facet of the operation of the institution. We might ask ourselves, as I have often been asked, how one compares the importance of a volunteer service with as vital a department as, say, nursing. This is a specious argument, of course, because although some departments are vital to the functioning of the hospital, in the sense that the institution could not exist without them whereas it could function without others, all departments are equally important in the total administration of a hospital that has a philosophy of the totality of patient care. I think it can be said safely that no voluntary hospital could today afford to maintain a department that is not equally as important as other departments.

EVERYONE MUST AGREE

As far as the administrator is concerned, therefore, the volunteer service should function as a department. It is not essential that there be a paid director of volunteers, although I believe this is advisable if the volunteer service is a sizable one. It is sufficient if the administrator thinks of the service as another department. It is not

Mr. Berke is director of Mount Zion Hospital, San Francisco.

sufficient, however, if he is the only person in the organization who thinks so. All administrative personnel, and all department heads, must think so too. This is relatively easy where there is a paid director of volunteers, either part time or full time.

The paid director becomes a part of the administrative team, and as such is accepted on her own merits and as a coequal by other department heads. She is a regular participant in administrative meetings, and shares in the general responsibility for policy making and planning. Under these circumstances, administrative integration is a natural consequence.

DIRECTOR NEEDS TACT

With a voluntary director, acceptance by the department heads becomes more difficult, and the administrator must spend quite some time in the complex area of human relationships to achieve this goal. Much depends on his attitude. Supervisors can readily sense when an administrator is truly interested in the development of a project, and with a sensitive volunteer director who knows how to ingratiate herself with department heads, a healthy relationship can soon evolve. It is especially necessary, though, that the voluntary director be sensitive to the feelings of others, because she has to deal with people who are working for their living, and who will be naturally suspicious and even resentful of someone who appears to be a dilettante, or a do-gooder. It will obviously take some time and work to overcome this, and only a person with strong motivations and a will to win will succeed.

It would seem apparent that careful thought must be given to the selection of a voluntary director. The paid director meets employes on their own terms. The voluntary director has more hurdles to overcome and must be very wary. The slightest intimation that she and her volunteers must be rendered homage for giving their time free, for instance, will be met with great resentment and resistance, as will a patronizing attitude of any sort.

A volunteer must work either with the patient or for the patient, depending on the volunteer's own wishes and likes; but in either case, her work must be coordinated with that of paid employes, and must ordinarily be supervised by them. Necessarily then, the volunteer must be liked and respected by the personnel she works with, and this will not happen if there is any suspicion of "do-goodism" on the part of the volunteer or voluntary director.

One could go on discussing the pitfalls facing the volunteer and the administrator, but actually the most difficult part of integrating volunteer services into the hospital is that of gaining acceptance by the medical staff. This is a most difficult thing to do, because the volunteer finds herself involved in a strange undefinable land of professional ethics, pride and rivalry —a land where advertising is frowned upon, but where, paradoxically, success depends upon the achieving of a reputation.

I have been connected with four different auxiliaries in hospitals located from the Atlantic to the Pacific, and in each case, when the question of volunteer service on patient floors is raised, I have had to listen to the same objections. They run something like this: "You know, I really don't mind myself, but I think a lot of our medical staff would object to having one of their wives on the floor, because then she'd have an opportunity to learn which doctors have how many patients in the hospital, and how could she avoid discussing it with her husband over dinner?"

The implication here is that physicians are not ordinarily aware of how many patients their colleagues are hospitalizing, and who has a large practice, and who has not. As though every physician on the staff is not aware of these facts! All one has to do is walk down the corridors in some of our hospitals in San Francisco and find posted on each door not the name of the patient but the name of the doctor.

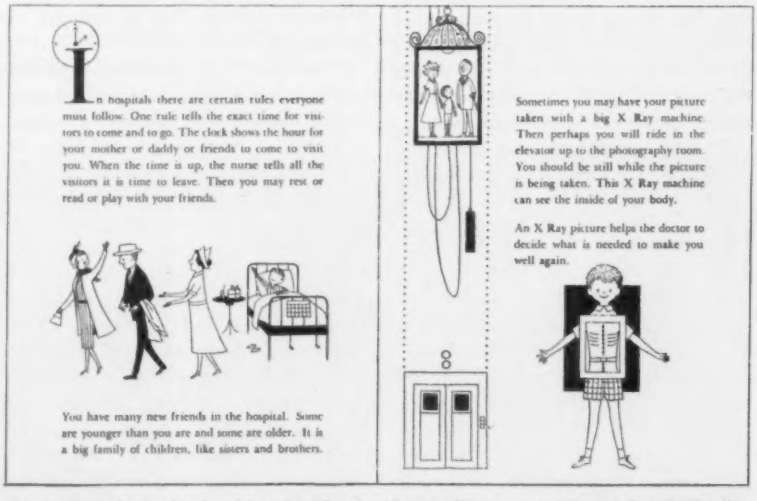
In each of the four hospitals, I have heard about, and tried without success to identify, the legendary volunteer who, having delivered mail or the library cart, or filled the water pitcher for a given patient, has been heard discussing the symptoms of the patient at a dinner party. And somehow the patient is always somebody who very much wanted to keep her diagnosis confidential or her presence in the hospital unknown.

Another consistent story in almost every hospital is that of the physician whose patient was served by a volunteer who, as it turns out, is always a friend of the patient or of the patient's family. The patient is invariably upset by the presence of this particular volunteer, because the patient's presence or diagnosis is one that must be kept unusually confidential.

These stories become part of the folklore of hospital volunteer services —the sort of thing you always hear from somebody who heard it from somebody else.

It is extraordinary too that so frequently volunteers know physicians

CHILDREN LEARN WHAT GOES ON "INSIDE THE HOSPITAL"



Two pages from the booklet "Inside the Hospital" prepared by Helen B. Radler for Memorial Center, New York City. It helps explain to children in simple language the reasons for hospitalizing them and the procedures that are involved.

personally and address them by their first names, which these physicians deeply resent because they don't like such familiarity on the wards, nor would they themselves ever dream of calling the volunteers by their first names.

Well, all these and other examples that will readily come to mind are only expressions of the physicians' own inner insecurities, and must be considered as the rationalizing of human beings who must be thought of as almost omniscient if they are to be successful, and yet who, because they are human beings, do err sometimes, and do have weaknesses.

DON'T DISREGARD CRITICISM

We must not, however, lightly disregard these comments and criticisms, or ignore them because they are rationalizations. They are very real stumbling blocks in the attainment of a cordial relationship in the hospital, and must be treated as such. The volunteer who works with patients is certainly working in a very delicate area, and the truth is that some volunteers have been indiscreet in their handling of confidential information to which they may have had ready access.

Like anything else in the field of human relationships, one error can offset many hours or even years of faithful service. It is somewhat akin to the legendary story of the patient who, seriously ill and on a stretcher, was left lying in the emergency room or in the admitting office, while a relative or friend went scurrying around to find the money for a deposit. Something of the sort undoubtedly did happen, but it was many years ago, and in the meantime the hospital has served thousands of patients well and generously—but it will never offset the one patient who was badly handled.

So with volunteers—one error, and a situation is created that will last for years.

I remember, in one hospital I was with, hearing the story of the volunteer—and this I can vouch for as a true story—who fell into a conversation with a patient who had had surgery. For some reason this volunteer questioned the competence of the surgeon. The patient was of course upset, and told her husband about it. He, in turn, questioned the referring physician, who passed the word on to the surgeon. There was a tremendous fuss and in the end the volunteer quit. The point is that this had occurred about 10 years before I joined the hospital, and yet the story was as fresh as though it had happened the previous week. Each time a new volunteer service was introduced, this same story arose to plague us, notwithstanding the fact that since the occurrence thousands upon thousands of hours of service had been given by volunteers with no untoward incidents.

How then is the volunteer service to handle this difficult problem of medical staff relations? Or rather, how is the administrator to handle it, because it is as much his problem as that of the volunteer. There is no easy answer, and all I can offer is my own opinion, based on successful operations I have observed.

First, just as the administrator must want the volunteer service, so must the medical staff. Unfortunately, when we talk of the medical staff, we are dealing with a large group, possibly as many as several hundreds of physicians, with several hundreds of opinions, whereas the administrator is a single individual, with a single point of view. The wisest move is to gain the full support of the organized representatives of the medical staff, whatever its terminology in any given hospital. The volunteers must have a friend at court—a member of the medical board assigned as liaison with the volunteers. Better would be a committee of the medical staff to handle volunteer relations, if possible. Whoever the contact, he should be sympathetic in his approach, and it is probably the administrator's responsibility to make sure that the physician selected understands the philosophy of volunteer services, and is desirous of developing this activity.

I am sure it is unnecessary to tell you that, unless the situation is a most unusual one, it will take years to gain complete acceptance and confidence by the majority of physicians, and that is the best we can hope for. Acceptance by all physicians will be found only in that special section of heaven set aside for good volunteers, where there are nothing but complacent patients, clean bedpans, and flower vases that never need filling. And even there you will only find acceptance by all physicians because very few physicians ever go to heaven.

On earth, we have to rely on a process of infiltration. Come like the Greeks, bearing gifts. After all, physicians are as materialistic as the rest of us, and we must keep reminding the medical staff that the volunteer services are in some measure responsible for the comfort and happiness of their patients. I have said that the volunteer must beware of the slightest trace of "do-goodism," of expecting to be profusely thanked or admired for her good deeds in this naughty world. On the other hand, her candle should not be hidden beneath a bushel. This I believe is the administrator's responsibility, too.

As an example, Mount Zion during the past few years has been seriously concerned over the need for development of an endowment fund—as I am sure every hospital has. In 1955, the women's auxiliary donated $50,000 to the hospital to be used for a number of different purposes. I have lost no opportunity to tell our physicians that, figured at 4 per cent, this represents the annual income from an endowment fund of *a million and a quarter.* It is a telling point and has never failed to create a vivid impression. It is a point anybody can understand, and it dramatizes the contribution made by our auxiliary.

LET'S NOT BE TIMID

This process of infiltration must be done carefully, but not too timidly. The volunteers must be continually pressing to add services in areas where physicians have been unwilling to see volunteers work, but they must be quick to gauge the depth of the resistance and must be prepared to retreat at any time. They must always use the path of least resistance, and be possessed of infinite patience. Above all, they must consolidate their gains. Each new service must be carefully planned and thoroughly rehearsed. Volunteers must be carefully screened, selected and trained. The objective should be to have as few errors as possible, and to make each operation a successful one before moving on to the next. Each successful operation brings an increased measure of acceptance and confidence.

Handled in this way, with each volunteer mindful of what we are endeavoring to accomplish, a sound integration of volunteer services into the hospital is not only likely but extremely probable, and the volunteer will find herself accepted as a complete partner in this complex business of patient care—and the care of the patient is, after all, the sole reason for the existence of the hospital and its volunteers.

Charge Open Doors Added to Fire Loss

Dispute about failure to keep fire doors closed follows tragic Christmas tree fire resulting in death of seven patients at Doctors Memorial Hospital, Minneapolis. Tree lights blamed for fire.

MINNEAPOLIS. — **Fire doors that were propped open, contrary to fire department orders, contributed to the loss of life when a Christmas tree fire at Doctors Memorial Hospital here December 23 resulted in the death of seven patients, Fire Chief Reynold Malmquist and Robert T. Palmer, fire prevention head, charged following the fire.**

A. G. Stasel, administrator of the 125 bed hospital, disputed the charge and said most of the fire doors in the hospital were closed. However, he acknowledged, some of the doors may have been left open. One nurse was overcome by smoke while she was trying to close the fire door on one of the patient floors, he reported.

Mr. Stasel added that the hospital had complied with the orders in a detailed instruction issued by the state fire marshal a year ago.

The fire began at 3 a.m. when a lighted Christmas tree in the hospital lobby (see diagram) burst into flames.

The tree was located only a few feet from the hospital switchboard and the switchboard operator, Frances Menefee, reported that she heard a "cracking noise" and turned to look at the tree just as it burst into flames.

"With the first floor fire door propped open, the smoke shot out the hallway and into the fire tower," Chief Malmquist explained. He added that doors to the fire tower on the third and fourth floors were also propped open so that smoke rose through the fire tower and back into the building on those floors.

"If those fire doors had not been open," he said, "the smoke and fire would have been confined to the lobby and would not have affected any of the patients."

All the patients who were suffocated by smoke were on the third floor of the hospital, it was explained. An eighth patient, an infant who was in a fifth floor nursery, died later at Minneapolis General Hospital, but the death was caused by congenital heart disease and was not related to the fire, doctors reported.

Chief Malmquist said smoke also was spread through the central stairway leading to upper floors. A door leading from the lobby to the central stairway was left open, he added.

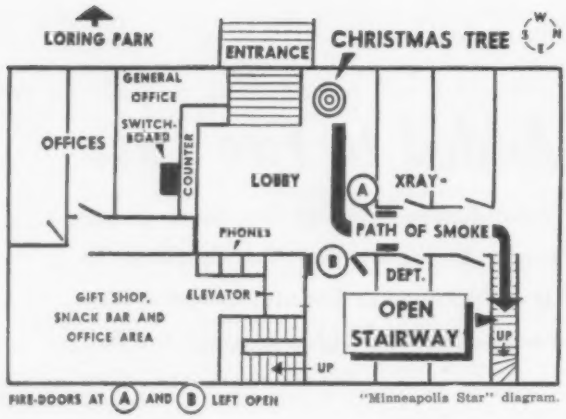
Immediately following the fire, the Minneapolis Fire Prevention Bureau ordered all hospitals and nursing homes to turn off Christmas tree lights.

The precise cause of the fire at Doctors Memorial was not determined. Chief Palmer said "defective wiring" of the tree was the apparent cause, but a power company investigator said the wiring was not defective and theorized that heat from the bulbs ignited the dry tree.

After detecting the fire, Miss Menefee called the building engineer, but

General view of Doctors Memorial Hospital, Minneapolis, as fire swept part of the building on December 23, killing seven patients and injuring a score of others. Firemen had to evacuate some 50 patients down ice-coated ladders.

Standing in a bucket of sand, a stump is all that remains of the Christmas tree which started a fire in the lobby of the hospital. The flames and smoke spread quickly through part of the building. (Photos from United Press Telephoto.)



A diagram of the lobby of the hospital showing position of Christmas tree which caught fire. Flames and smoke spread through open fire doors and stairs.

before she could call the fire department, lights in the lobby and at the switchboard went out, apparently as the result of a short circuit caused by the fire. Miss Menefee then called the fire department from a phone in the nursing superintendent's office with a direct outside line.

Firemen and police rescue squads arrived at the hospital from near-by stations "within a minute or two," it was reported.

Fortunately, occupancy was at the lowest level for the year, with only 67 patients remaining in the hospital. Approximately 30 patients had left the hospital to spend Christmas at home, and no surgical operations had been performed for two days preceding the fire.

Fire and police department rescue workers evacuated patients, mostly by extension ladders to windows of patients' rooms. Nurses on the hospital staff assisted in the rescue operation.

Nurses on duty in the fifth floor nursery at the time of the fire, especially, were praised by hospital and fire department authorities for their courage and devotion to duty in the emergency. The nurses covered the infants' faces with damp cloths to protect against smoke until the babies could be removed by firemen, they explained.

Following evacuation from the hospital, patients were taken to near-by apartment buildings until ambulances could transport them to other hospitals. Eventually, 45 patients were taken to Minneapolis General Hospital. Others were removed to St. Mary's, Northwestern, St. Barnabas and Lutheran Deaconess hospitals.

Damage to the hospital building was estimated at $100,000. The fire lasted only 10 or 12 minutes, firemen said.

Mr. Stasel said nurses at Doctors Memorial were trained in fire emergency duties by the Fire Prevention Bureau and the hospital had a fire safety plan in a printed booklet, "What to Do in Case of Fire."

Under the heading "General Rules," the booklet stipulates, "Doors to stairs to be closed at all times." In addition, a city ordinance provides that hospitals must be equipped with fire doors having self-closing devices, Chief Palmer said. However, he added, the ordinance does not specify that doors cannot be propped open.

In 1952, Chief Palmer said, the hospital was ordered in writing to remove all checks and blocks from fire doors. Since that time, the hospital has been reminded verbally to stop propping these doors open.

At a meeting of state and city fire safety officials following the disaster, it was reported that the hospital had been operating under temporary licenses pending complete compliance with fire safety regulations. Donald Erickson, city building inspector, said that a permanent license for 1957 had been approved by the city council December 14 and was in process of being issued. Structurally, the hospital is in compliance with city fire safety regulations, Mr. Erickson said.

Doctors Memorial was built in 1912 by Dr. George Eitel, who owned and operated the hospital until his death in 1925. Later, the hospital was operated by the Nicollet Clinic. Until recently, doctors on the staff held a majority of positions as members of the board of trustees, but as their terms were completed, they were being replaced by community leaders appointed to the board vacancies.

Minneapolis General Aids in Evacuation of Fire Victims, Provides Emergency Care

MINNEAPOLIS. — Disaster emergency plans at General Hospital here functioned efficiently in the emergency caused by the fire at Doctors Memorial Hospital December 23, it was reported.

Mobilization of General's staff and facilities began as soon as the night supervisor received word of the fire and notified Administrator Donald F. Smith.

Mr. Smith ordered all private ambulances that could be summoned to go to Doctors Hospital to assist in the evacuation of patients. Mr. Smith and an assistant, Vernon Carlson, themselves drove the two General Hospital ambulances to Doctors Hospital and took part in organization of the evacuation procedure.

The house staff at General, including 25 interns and 15 residents, staffed the receiving ward to give first aid to patients evacuated from Doctors Hospital and "sort" patients for further care. An unused ward was opened and patients were sent there following examination in the receiving ward, it was reported.

Nurses scheduled to go on duty at Doctors Hospital in the morning were notified to report to General instead, it was explained.

Patients' records were transferred from Doctors to General and Red Cross volunteer workers compiled lists of all patients and notified families of their transfer and condition.

In addition to ambulances from General Hospital and private services, police department patrol wagons, equipped with mattresses, were also used to transfer patients.

As patients were cared for at General Hospital following the fire, cleanup operations began at Doctors Memorial. Albert G. Stasel, administrator at Doctors, expected the hospital would be ready to readmit transferred patients in about 10 days.

Pending restoration of patients' facilities and supplies, physicians who had patients scheduled for admission to Doctors Memorial took them instead to other hospitals, which temporarily waived the requirement that only patients of staff members could be admitted.

PROTOTYPE STUDY: 400 BED HOSPITAL

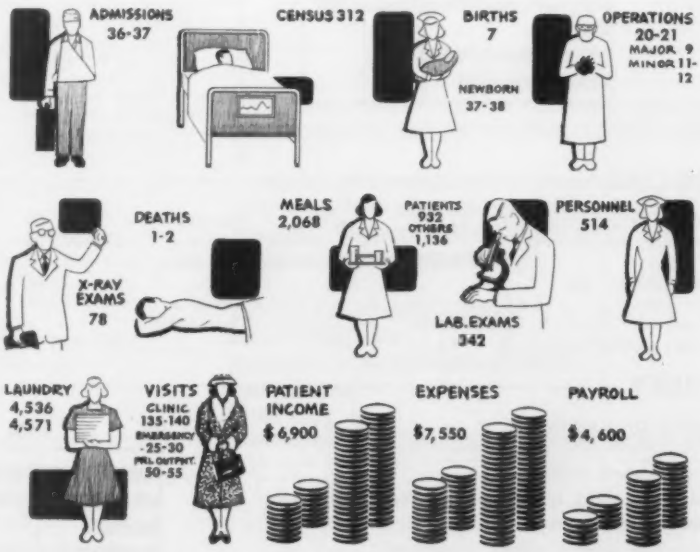
Continuing a new series of "prototype studies" of hospital operations and activities, with up-to-date information on principal departments

This expanded prototype study of the 400 bed hospital analyzes operations in greater detail than has ever been done before. The prototype study becomes a useful tool for self-evaluation by hospitals in this size group, and a guide to administrative planning. Subsequent studies will present similar detailed information describing hospitals in the larger size groups

LOUIS BLOCK, Dr. P.H.
Chief, Research Grants Branch
Division of Hospital and Medical Facilities
Public Health Service, Washington, D.C.

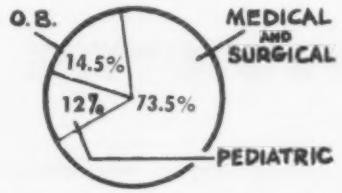
AN AVERAGE DAY'S ACTIVITIES

In this prototype of hospital operation for the 400 bed nonprofit, general hospital, national data were used whenever available. Regional, state or special group information was adjusted to the national basis. This represents the composite or average of existing statistical data. As new or more refined information becomes available, the content may need revision. It does not generally reflect affiliated services with other hospitals and sources; nor does it necessarily indicate the ideal institution.



BED DISTRIBUTION

In more than half of these hospitals, medical, surgical, obstetrical and pediatric patients have beds specifically set aside for their use. For this reason they are considered as major services to such a hospital type and size group. The foregoing bed distribution will be affected by assignments to additional services discussed hereafter.



In addition to the basic grouping of patients found in more than half of these hospitals, the 400 bed, nonprofit, short-term, general hospital may make specific bed assignments for other patient groups. Because they occur in less than half of these hospitals they are considered as additional service groupings. The following shows these additional service groupings, the frequency of their occurrence, and the average number of beds assigned them:

ISOLATION OR CONTAGIOUS PATIENT BEDS—
a. Frequency of occurrence.....1 in 4 hospitals
b. Average number of beds assigned.....16

CHRONIC (LONG-TERM) PATIENT BEDS—
a. Frequency of occurrence.....1 in 11 hospitals
b. Average number of beds assigned.....49

NERVOUS AND MENTAL PATIENT BEDS—
a. Frequency of occurrence .....1 in 4 to 5 hospitals
b. Average number of beds assigned.....45

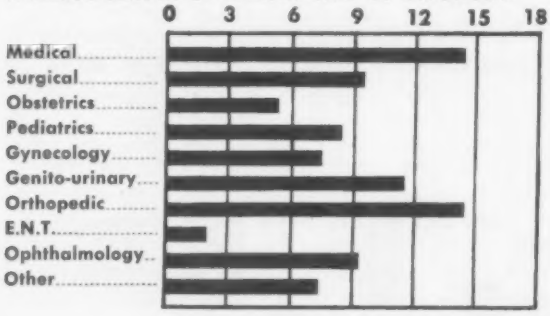
TUBERCULOSIS PATIENT BEDS—
a. Frequency of occurrence.....1 in 9 hospitals
b. Average number of beds assigned.....29

UTILIZATION

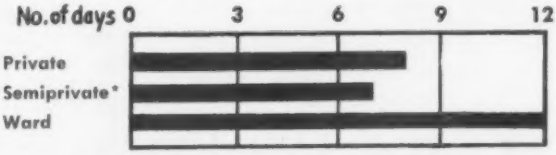
The kind, type and number of patients admitted to and using the 400 bed general hospital are as follows:

Annual number of adult admissions.....13,200
Annual number of admissions per bed.....33
Annual number of live births.....2,520
Annual number of premature births.....140-150
Annual number of stillbirths.....28
Annual number of sets of twins.....22
Annual number of sets of triplets.....1-2
Annual number of patient days of care...114,000
Annual number of newborn infant days of care.....13,750
Average daily adult census.....312
Average daily newborn census.....37-38
Percentage of adult occupancy.....78
a. Private.....70
b. Semiprivate.....85
c. Ward.....75
Percentage of newborn occupancy.....65
Average length of patient stay.....8.5 days

AVERAGE LENGTH OF PATIENT STAY BY DIAGNOSIS:



AVERAGE LENGTH OF PATIENT STAY BY ACCOMMODATION:



*Semiprivate patients usually stay a shorter time than do either private or ward patients. Among the usual explanations for such an occurrence is that the pressure of finances requires the semiprivate patient to get back to gainful employment as soon as possible. Private patients may be in a better position to afford slightly longer convalescence in the hospital. Ward patients, on the other hand, may have other factors dictating or affecting the length of time they stay. Among these factors are usually those of more advanced cases of illness and home conditions not conducive to convalescence.

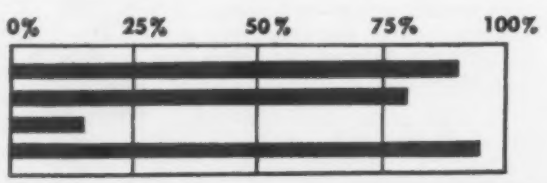
FINANCIAL

Total annual expenses	$2,750,000	% payroll of total expenses	61
Total expenses per patient day	$ 24.00	Total annual income	$2,800,000
Average expenses per patient stay	$ 204	Total income per patient day	$ 24.60
Annual payroll	$1,675,000	Annual patient income	$2,515,000
Payroll per patient day	$ 14.65	Patient income per patient day	$ 22.10

% patient income of total	90
Total assets	$6,000,000
Total assets per bed	$ 15,000
Plant assets	$4,000,000
Plant assets per bed	$ 10,000
% plant assets of total assets	67

NURSERY

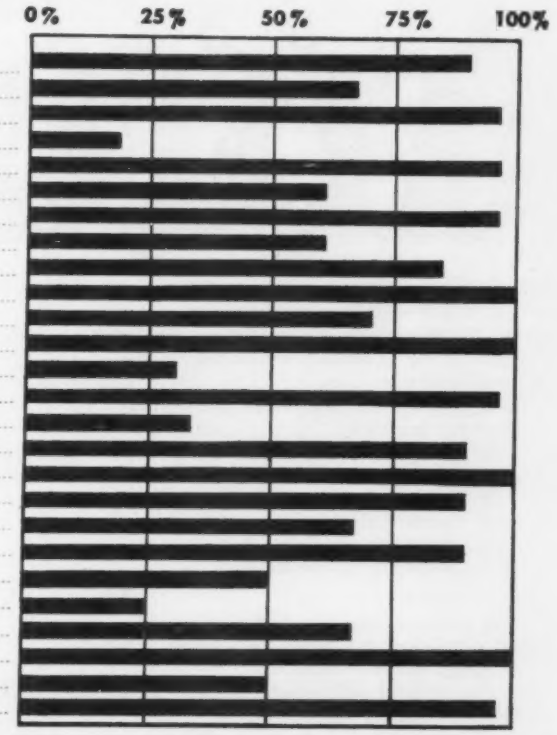
NUMBER OF BASSINETS.....58
Hospitals having special nurseries for premature infants
Hospitals using bead bracelets for identification
Hospitals using tape bracelets for identification
Hospitals having infant incubators*
*Average number per hospital.....9-10



SERVICES

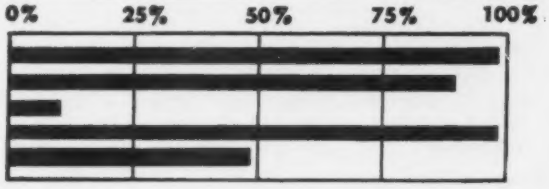
Services which might be provided but which are generally found to occur in less than 50 per cent of the facilities of this size group are considered as additional. Certain of these services may be provided through arrangements with other hospitals and sources. Such arrangements are not reflected in the frequencies shown.

Frequency of hospitals offering:



RADIOLOGY

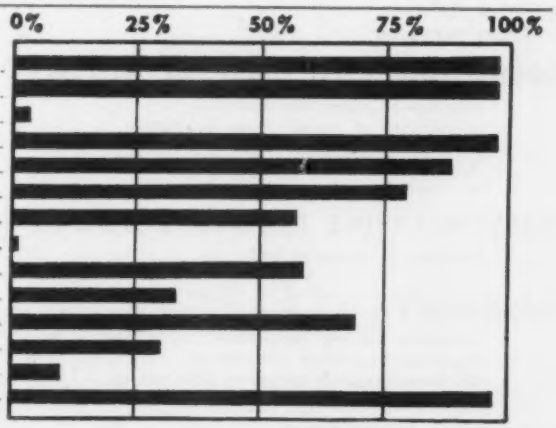
Frequency of hospitals having:



X-ray examinations, annually 28,000-29,000

LABORATORY

Frequency of hospitals having:



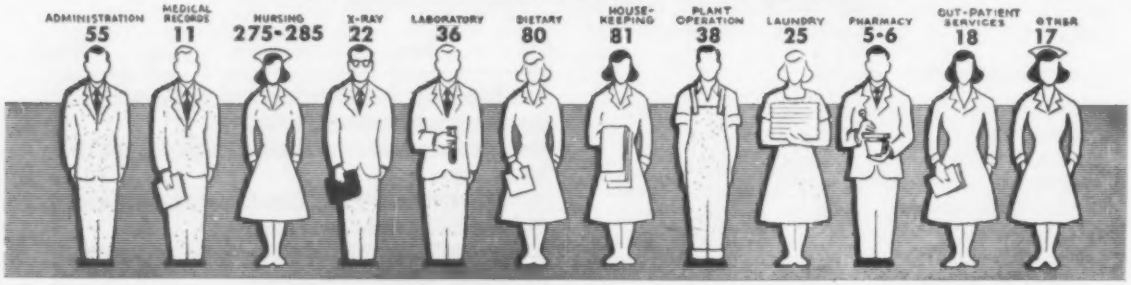
Annual clinical laboratory examinations.....125,000

OUTPATIENT DEPARTMENT

Number of annual clinic visits.....49,500-50,000
Number of annual emergency visits..10,200-10,250
Number of annual private outpatient visits 18,800-18,900

PERSONNEL

DEPARTMENTAL DISTRIBUTION OF PERSONNEL:



Number of full-time personnel	670
Number of full-time personnel per 100 patients	210
Number of full-time employes per bed	1.7
Number of full-time employes per occupied bed	2.1
Hospitals having volunteers other than women's auxiliary	3 in 4
For those hospitals having volunteers, average number per hospital	101
Hospitals having a women's auxiliary	More than 4 in 5 hospitals
For those hospitals having women's auxiliary, average number of members per hospital	615
Average number of members of women's auxiliary working in the hospital	137
Nursing personnel:	
a. Total graduate nursing personnel	174
(1) Administrative graduate nursing personnel	4
(2) Full-time instructors	8
(3) Supervisors and assistants	12
(4) Head nurses and assistants	28
(5) General duty nurses full-time	88
(6) General duty nurses part-time	34
b. Private duty nurses	38-39
c. Practical nurses	29-30
d. Attendants	34
e. Nurse's aides	84-85
f. Ward maids	18-19
g. Orderlies	29-30
Medical technologists:	
a. Registered full-time	7
b. Registered part-time	0-1
c. Other full-time	11
d. Other part-time	2
X-ray technicians:	
a. Registered full-time	4
b. Registered part-time	0
c. Other full-time	4
d. Other part-time	0
Pharmacists:	
a. Full-time	3
b. Part-time	0-1
Medical record librarians:	
a. Registered full-time	1-2
b. Registered part-time	0
c. Other full-time	1
d. Other part-time	0
Other medical records personnel:	
a. Full-time	8-9
b. Part-time	1-2
Dietitians:	
a. Full-time	6
b. Part-time	0
Occupational therapists (of those that have them):	
a. Registered full-time	1
b. Registered part-time	0
c. Other full-time	1
d. Other part-time	0
Physical therapists:	
a. Registered full-time	2
b. Registered part-time	0
c. Other full-time	1
d. Other part-time	0
Medical social workers:	
a. Full-time	4-5
b. Part-time	0

OPERATING AND DELIVERY ROOMS

Number of operating rooms	10
a. Number of major operating rooms	6
b. Number of minor operating rooms	4
Annual number of operations	7300
a. Annual number of major operations	3200
b. Annual number of minor operations	4100
Number of delivery rooms	3-4
Number of labor beds	6-8
Annual number of deliveries	2550

POSTOPERATIVE RECOVERY ROOMS

Number of recovery beds	12
Hospitals having a postoperative recovery room	2 in 3

PHARMACY

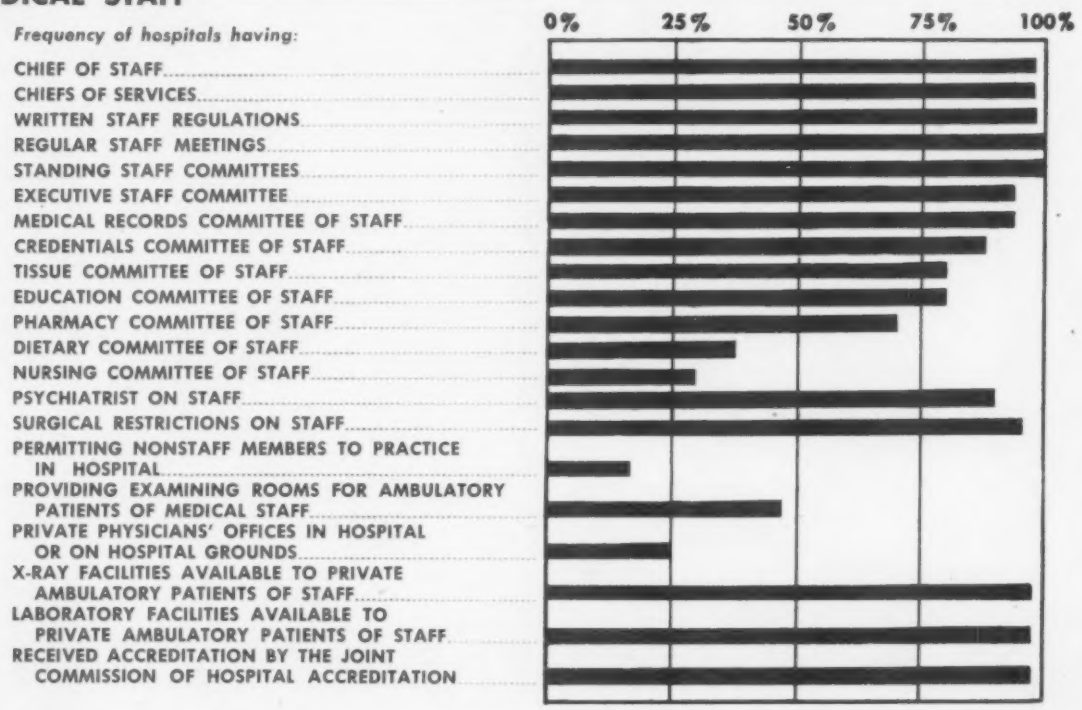
Hospitals having formulary	Almost 7 in 10
Hospitals operating pharmacies	All
Of those hospitals operating pharmacies, having full-time licensed pharmacist	Almost all
Of those hospitals having full-time pharmacists, average number	3
Of those hospitals operating pharmacies, manufacturing parenteral solutions	1 in 6

MEDICAL RECORDS

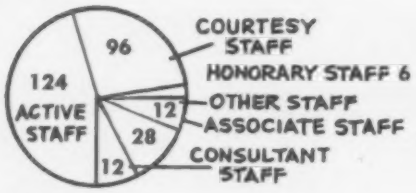
Hospitals microfilming medical records	3 in 5
Annual number of deaths	377
Per cent deaths of admissions	2.8
Annual number of autopsies	165
Per cent autopsies of deaths	44
Annual number of deaths released to legal authorities	39
Per cent such deaths (6) of admissions	0.3
Hospitals using standard nomenclature of diseases and operations	All hospitals

MEDICAL STAFF

Frequency of hospitals having:



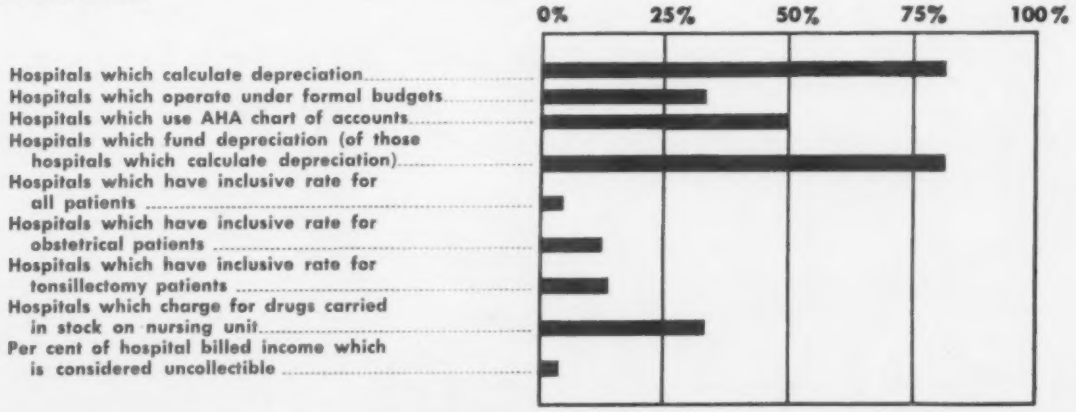
278 STAFF PHYSICIAN APPOINTMENTS



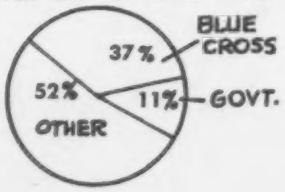
PER 100 BEDS

ACTIVE STAFF	31
ASSOCIATE STAFF	7
COURTESY STAFF	24
CONSULTANT STAFF	3
HONORARY STAFF	1-2
OTHER STAFF APPOINTMENTS	3

ACCOUNTING



PER CENT OF BILLED CHARGES PAID



STARTING MONTHLY SALARY:

General duty nurse	$250
Untrained women	143
Untrained men	161
Clerks	173
Practical nurse	182

HOURS OF WORK PER WEEK:

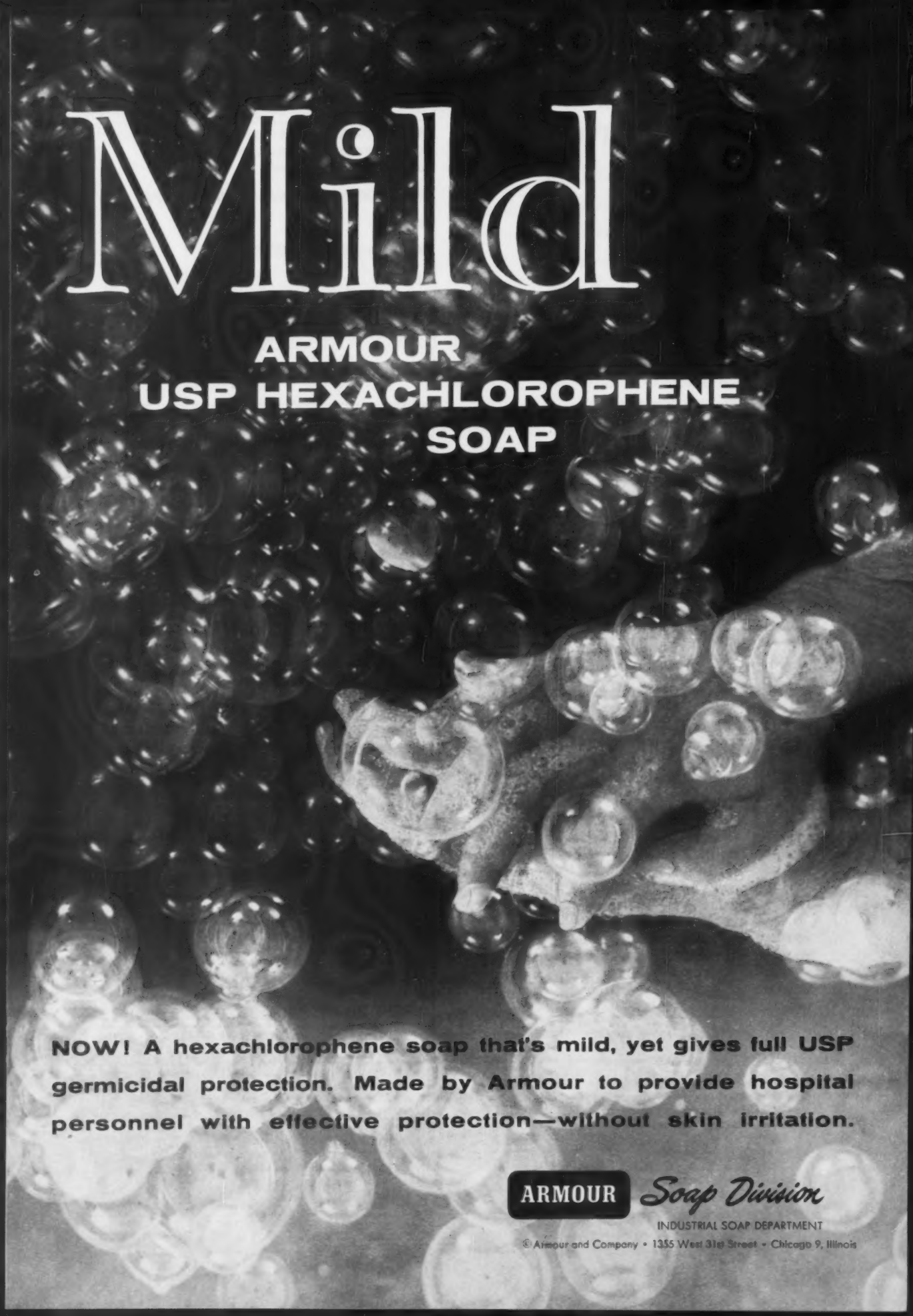
General duty nurse	41
Untrained women	43

AVERAGE ROOM RATES:

One-person room	$17.20
Two-person room	13.45
Multibed room	11.20

AVERAGE DAYS OF VACATION AFTER ONE YEAR OF EMPLOYMENT:

General duty nurse	15
Untrained women	12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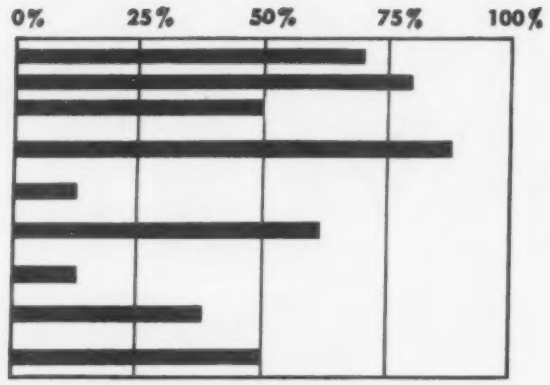


Hospitals paying general duty nurses extra pay for:
- a. Evening shift
- b. Night shift

Hospitals paying overtime in cash

Hospitals offering automatic salary increases to general duty nurses

Hospitals offering complete maintenance to general duty nurses

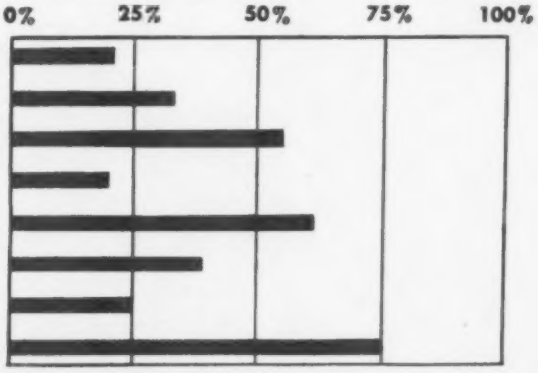
Hospitals offering no maintenance to general duty nurses

Hospitals offering complete maintenance to untrained women

Hospitals offering no maintenance to untrained women

Hospitals requiring advance payment for patients responsible for paying own bill

ADMINISTRATOR



Frequency of hospitals:

Where chief administrative officer is a physician

Where chief administrative officer is a graduate nurse

Where chief administrative officer is other than a physician or a nurse

Where chief administrative officer is a graduate of a college course in hospital administration

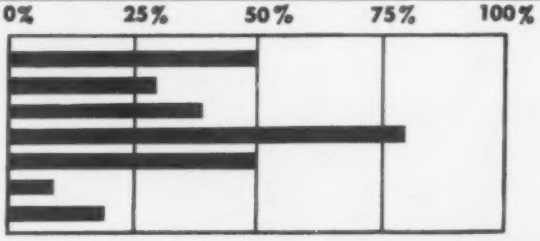
Where chief administrative officer is a male

Where chief administrative officer is a female

Having administrative staff member on duty at night

Delegating administrative responsibility to night supervising nurse

RELIGIOUS



Frequency of hospitals with:

A CHAPEL

A MEDITATION ROOM FOR PRAYER

AN ORGANIZED VISITING CLERGY STAFF

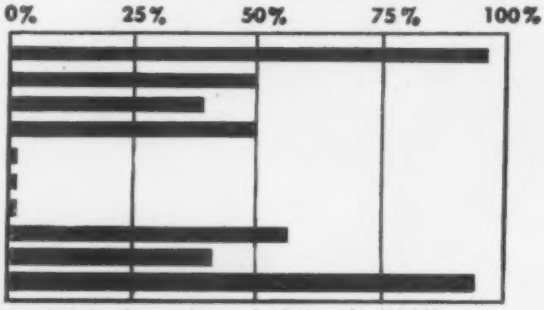
CHAPLAIN AVAILABLE

FULL-TIME CHAPLAIN

PART-TIME CHAPLAINS

CHAPLAIN ON CALL ONLY

DIETARY



Frequency of hospitals with:

FULL-TIME DIETITIANS

CENTRAL FOOD SERVICE LAYOUT

SELECTIVE MENUS FOR ALL PATIENTS

SELECTIVE MENUS FOR PRIVATE PATIENTS ONLY

NO SELECTIVE MENUS

MANUAL AND CENTRALIZED DISHWASHING

MANUAL AND DECENTRALIZED DISHWASHING

MECHANICAL AND CENTRALIZED DISHWASHING

MECHANICAL AND DECENTRALIZED DISHWASHING

GAS AS FUEL USED FOR COOKING

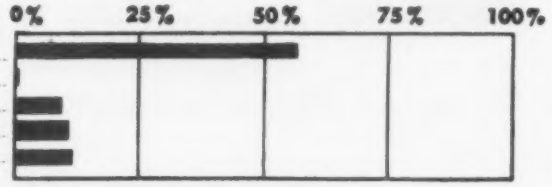
Number of meals served annually, 755,000; (a) patient meals, 340,000; (b) employe and other meals, 415,000.

LAUNDRY

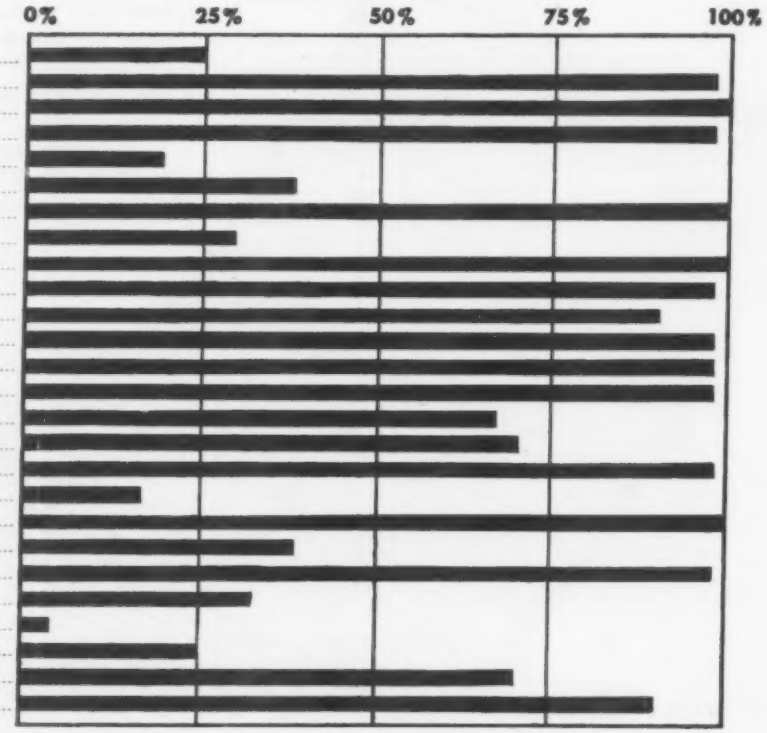
Hospitals which operate own laundry and process all soiled linen	9 in 10
a. No. of lbs. processed per week	31,750-32,000
b. Number of lbs. processed per patient day	14-15
c. Number of lbs. processed per year	1,651,000-1,664,000
Hospitals which operate own laundry and process only a part of soiled linen	1 in 25
a. No. of lbs. processed per week	29,000-29,250
b. Number of lbs. processed per patient day	13
Hospitals which do not operate own laundry	1 in 33
a. No. of lbs. processed per week	21,000-21,250
b. Number of lbs. processed per patient day	11-12

ADMITTING

Frequency of hospitals:



Routinely treating:



Admitting psychiatric patients	More than 1 in 3
Of those general hospitals admitting psychiatric patients:	
a. Caring for such patients in separate buildings	1 in 6
b. Caring for such patients in separate departments in same building	Almost 3 in 5
c. Caring for such patients in no separate facilities	2 in 5

PUBLIC RELATIONS

Frequency of hospitals using:

Booklet for employes	2 in 5	Patient opinion poll	almost 3 in 5
Booklet for patients	1 in 3	Personnel opinion poll	1 in 10
Regularly published house organ	almost 1 in 2	Medical staff opinion poll	1 in 9
Printed annual report	1 in 2	Community opinion poll	1 in 33
		Using no such poll	2 in 5

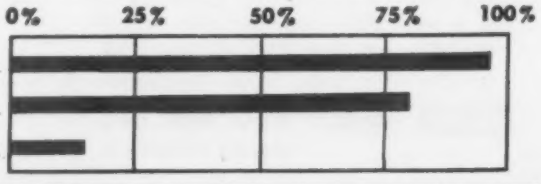
SAFETY

Frequency of hospitals with:

Organized safety committee	1 in 3	Own written plan for mobilization of employes and medical staff	7 in 10
Written fire emergency and evacuation plans	almost 4 in 5	Written mobilization plan integrated in Master Community Plan	3 in 5
Regularly scheduled fire drills	1 in 2	Representation on a Community Disaster Planning Committee	4 in 5

PURCHASING

Frequency of hospitals with:



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Psychiatric Admissions to State Hospitals

Case study of the nature of the patient load and treatment programs in state hospitals designed to help in planning adequate psychiatric facilities

FOR those concerned with the planning and design of psychiatric treatment facilities, information concerning the nature of the patient load and treatment programs is of primary importance. With this in view, a case record study of 1533 admissions to the psychiatric services of six general hospitals and 8541 admissions to the intensive treatment services of six state hospitals during 1953 was carried out.

The study of admissions to the general hospitals was reported in the December 1956 issue of The MODERN HOSPITAL. Following is the report on admissions to state hospitals. Hospitals were selected for study on a basis of size, geographical location, and activity of treatment program. They were scattered throughout the United States as shown in the accompanying table.

Authors are Charles K. Bush, M.D., Lucy D. Ozarin, M.D., Alston G. Guttersen, A.I.A., John M. Russell, M.S.W., Frances Wright, B.A.

From the Architectural Study Project of the American Psychiatric Association. Dr. Bush was the former director; Dr. Ozarin is the present director.

The Architectural Study Project of the American Psychiatric Association was established in 1952 to furnish information and assistance to psychiatrists and architects in planning physical facilities for psychiatric patients.

This study was begun under a grant from the Rockefeller Foundation and the Division Fund. A grant from the United States Public Health Service permitted its completion.

The survey of 8541 admissions to six state hospitals produced the following data.[1]

Legal Status on Admission. Whether a patient entered the state hospital voluntarily or was committed depended on hospital admission policies and the state legal requirements. (Some states also provide other legal paths by which a patient may enter a state hospital, such as the two-physician certificate.)

With the exception of S-3, where 67 per cent of the admissions were voluntary, the voluntary admission rate at the other five hospitals was less than 35 per cent and at S-4 a single voluntary admission occurred.

The alcoholics constituted the largest single group of voluntary admissions, followed by patients with schizophrenic disorders. These two diagnostic groups accounted for more than half of the voluntary admissions.

The numbers of criminally insane were very few, totaling only 19 patients at the six state hospitals. (Many states segregate this group in one hospital in the state.)

Sex and Age. Of the 8541 admissions to the six state hospitals, 56 per cent were men in contrast to the six general hospitals studied, where 63 per cent of the admissions were women. However, at two state hospitals (S-2 and S-4) the number of female admissions exceeded the number of males (Fig. 1).

Differences in the male and female admission rates were more noticeable in certain diagnostic categories. Among the 1990 alcoholics the ratio of male to female patients was more than 5 to 1. Hospitals S-2 and S-4, where females were in the majority, also had the lowest admission rates for alcoholism.

In contrast to the alcoholic group, there were 515 women and 229 men admitted for treatment of affective disorders (manic depressive reactions and involutional melancholias). The sex difference was less marked in the schizophrenic group where there were 1357 women and 1004 men.

Two hundred thirty-one women and

[1]The records of 251 patients at two day care centers and 630 patients at two outpatient clinics were also studied. However, records at these facilities were not comparable to the records of the general and mental hospitals.

TABLE 1—STATE HOSPITALS INCLUDED IN STUDY

State Hospital	Total Beds	Intensive Treatment Service Number of Beds	Number of 1953 Admissions Studied
S-1	4908	(no separate service)	1745
*S-2	368	184	421
**S-3	170	170	1324
S-4	3022	208	1200
S-5	2813	120	1108
S-6	8546	314	2743

*This was a 1500 bed state hospital which was being gradually activated. Hospital admission policy excluded patients over the age of 45 and those with a psychiatric illness of more than 5 years' duration.
**This was a receiving hospital which was part of a state hospital system but accepted only patients for intensive treatment.

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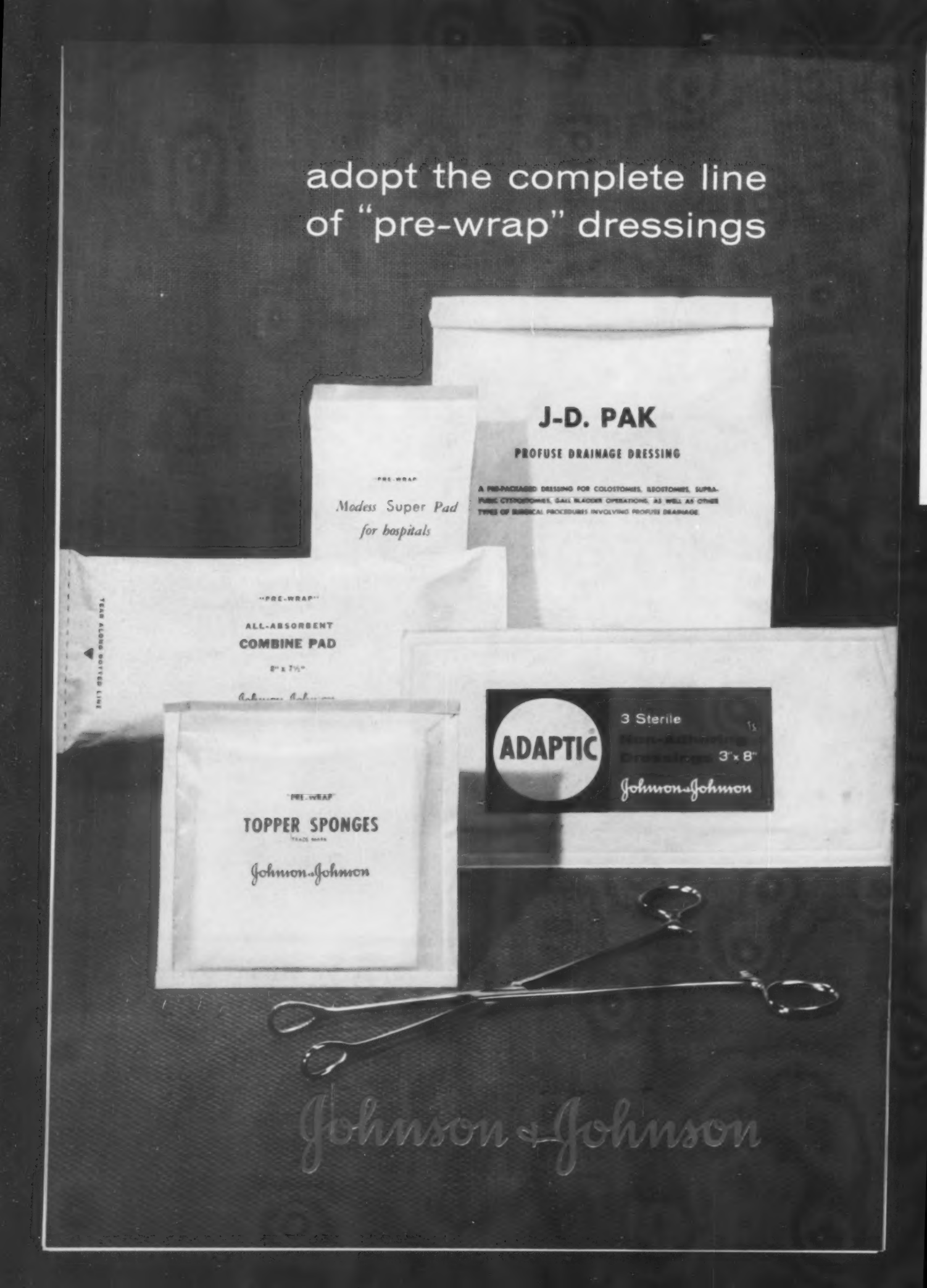
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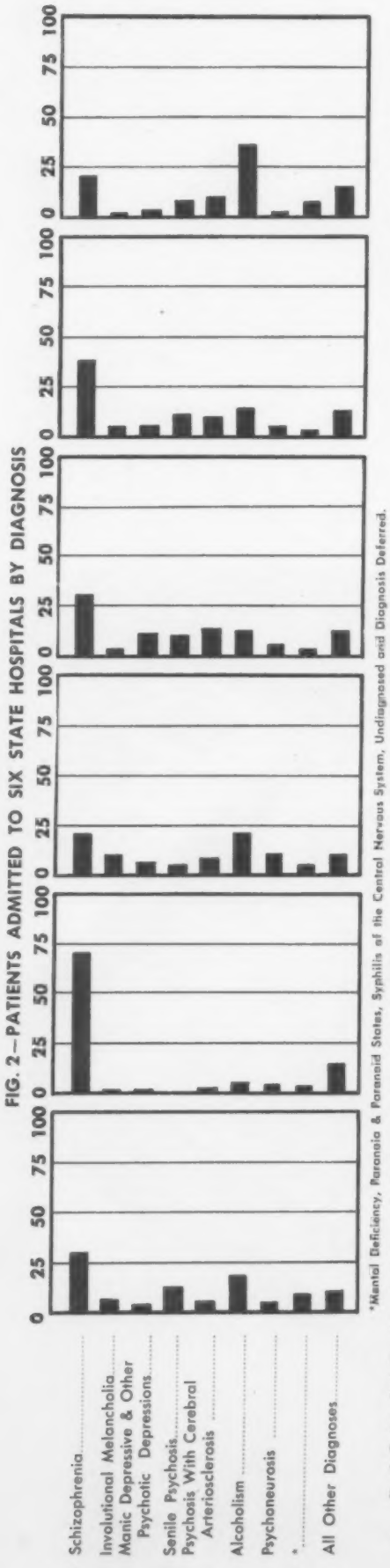

*Mental Deficiency, Paranoia & Paranoid States, Syphilis of the Central Nervous System, Undiagnosed and Diagnosis Deferred.

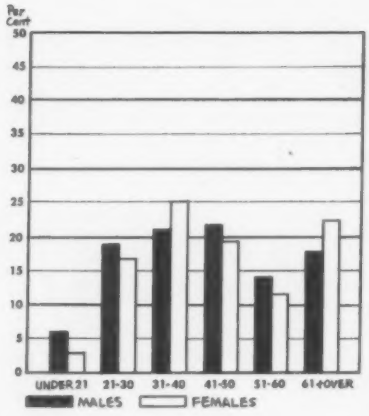

FIG. 1—PATIENTS ADMITTED TO SIX STATE HOSPITALS BY AGE AND SEX

166 men were admitted with psychoneurotic disorders.

More men than women had illnesses associated with syphilis of the central nervous system as well as conditions for which no diagnosis was found in the record.

Patients between the ages of 20 and 70 constituted 83 per cent of the total. More patients over 70 were admitted to state hospitals than were found in the general hospital study. At Hospital S-2, which as a matter of policy did not regularly admit patients over 45 years of age, fewer than 2 per cent of the admissions were over 60. At S-4 the group over 60 years of age accounted for 34.4 per cent of the admissions.

Diagnosis. Patients with schizophrenic disorders (27.6 per cent) and alcoholism (23.3 per cent) accounted for more than 50 per cent of all admissions to the state hospitals in this study. The proportion of schizophrenic patients varied from 19.6 per cent at Hospital S-6 to 70.3 per cent at S-2 (Fig. 2).

Those with senile psychosis and psychosis with cerebral arteriosclerosis accounted for an additional 16.4 per cent of all admissions. However, they varied from 1.4 per cent of the admissions at S-2, where hospital policy excluded patients over 45 years of age, to 24.3 per cent at S-4.

Physical Condition on Admission. The proportion of ambulant patients at the state hospitals ranged from 76.7 per cent at S-5 to 94 per cent at S-2. This is a larger number than was found in the general hospitals. The numbers of semiambulant (those requiring wheel chairs or assistance in moving about) and bedfast patients were approximately equal, representing 8.4 per cent and 8 per cent of the total admissions, respectively (Fig. 3).

The older the patients, the fewer ambulatory and the more bedfast there were. Of those under the age of 50, 91.6 per cent were ambulatory. Slightly less than half of the patients over 70 were ambulatory; 36.7 per cent of the 721 semiambulant and 46.4 per cent of the 670 bed patients were over 70.

Emotional Condition. There was considerable difficulty in assessing the emotional condition of patients as recorded in the case files. It was noted, however, that more than 55 per cent of all patients were cooperative on admission and only 6.4 per cent were combative.

Psychiatric Treatment. The advent of tranquilizing drugs has changed considerably the treatment picture in state hospitals. Reports in the literature indicate that the use of electric and insulin shock therapies has markedly decreased as has the use of hydrotherapy. As patients have become more accessible and responsive under the influence of the drugs, patients' needs for psychotherapy and occupational and recreational therapies have increased.

In 1953, the treatment picture in the six state hospitals studied showed that 26.4 per cent of the 8541 admissions received electric shock therapy. From 60 to 64 per cent of the patients with schizophrenic disorders, involutional melancholia and manic depressive psychosis received this treatment, and they accounted for 83.2 per cent of all the admissions who received electric shock. Relatively few patients

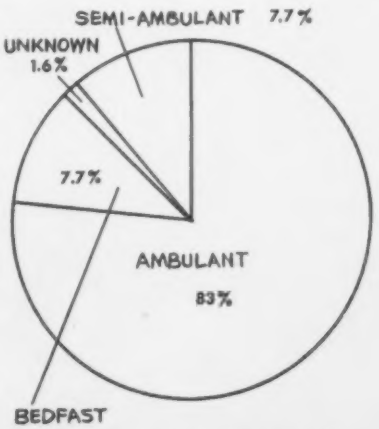

FIG. 3—PATIENTS ADMITTED TO SIX STATE HOSPITALS: PHYSICAL CONDITION ON ADMISSION

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with other psychiatric diagnoses received shock treatment.

Insulin shock therapy was used infrequently. Hospitals S-2 and S-3 treated respectively 14.7 per cent and 13.6 per cent of their admissions. Psychoneurotic patients received insulin shock therapy oftener than patients with other diagnoses and it is likely that most of these patients received subcoma rather than coma treatment.

Hydrotherapy was received by 19.1 per cent of the patients, with the rate of use varying between hospitals from 0.9 per cent to 39.1 per cent. The use of hydrotherapy was greater at the state hospitals than in the general hospitals.

Approximately one-third of the patients at state hospitals participated in some type of occupational or recreational therapy. Its use was less common in the state hospitals than in general hospitals. Of those for whom only one type of occupational or recreational therapy was reported, the largest number participated in music therapy. This was followed by games, drawing, embroidery, movies and sewing in order of frequency.

More women than men took part in occupational and recreational therapy. This may be related to the finding that industrial therapy assignments were more frequently given to men than women.

Drug therapies were used by three hospitals (S-2, S-4 and S-6) for fewer than 1 per cent of their patients, while at S-2, 63.7 per cent of the patients were so treated. Except for occupational and industrial therapies, chemotherapy was the commonest treatment for alcoholics.

At Hospital S-5, 66 patients, or 6 per cent of the admissions, participated in psychodrama, which was a part of the treatment program.

Only 16 cases of psychosurgery were recorded among the 8541 patients while on the intensive treatment services of the six state hospitals.

Special Medical Procedures. The routine admission procedures at the state hospitals were similar to those in the general hospitals and included physical and mental examinations, urinalysis, blood count, serology and, at some hospitals, chest x-rays.

The percentage of patients receiving special laboratory work ranged from 2 per cent at Hospital S-2 to 56.8 per cent at S-4. At Hospital S-2, 5.7 per cent of the patients had x-rays, compared with 32.8 per cent of the admissions at S-4. At Hospital S-4, 25.2 per cent of the patients received spinal fluid examinations.

The use of other special procedures showed considerable variation among hospitals. At S-2, 12.6 per cent received physical therapy. At S-4 only 3.1 per cent received physical therapy and at the remaining hospitals the rate was even lower. At Hospital S-5, 14.2 per cent of the patients had electrocardiograms taken; at S-6 this was true of 8.8 per cent of the patients, and fewer than 5 per cent at all other hospitals had this test.

Electroencephalograms were recorded in 14.1 per cent of the patients at S-5, 7.3 per cent at S-1, and fewer than 2 per cent at all other hospitals.

The basal metabolic rate was determined in 54 of the 8541 admissions.

LESS USE OF SPECIAL PROCEDURES

Apart from the routine admission procedures, there was less use of special medical procedures on the intensive treatment services of the state hospitals than was the case in the general hospitals.

Length of Stay. During the first week of hospitalization, 28 per cent of the 8541 patients were discharged or transferred to another service in the same hospital. The rate of departure from the intensive treatment service was greater during the first three days and thereafter began a gradual drop. This large proportion of patients who left the service may have been augmented by the emergency and observation cases where disposition or commitment within 72 hours was required by state law.

At Hospital S-2, 3.8 per cent of the patients left the intensive treatment service during the first week, while at S-1, this was true of 44.4 per cent of the admissions.

At Hospital S-2 more than 80 per cent of the patients remained longer than two months on the intensive treatment service; at S-4 only 8.9 per cent remained that long. The greater length of stay observed at S-2 may be linked to the high proportion of schizophrenics (70.3 per cent) admitted, more than twice that of any other hospital.

More than 50 per cent of the schizophrenics admitted to the six state hospitals remained on the intensive treatment service for longer than two

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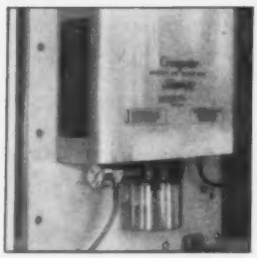

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months and constituted the largest single diagnostic group to remain this long.

The absence of a significant number of elderly patients at Hospital S-2, where the admission policy excluded patients over 45 years of age, may be an additional factor in producing the relatively greater length of stay since those with a senile psychosis or a psychosis with cerebral arteriosclerosis tended to be transferred rather quickly from the intensive treatment service. Only 8 per cent of the patients with these diagnoses remained longer than two months on intensive treatment services.

Except during the first two days after admission, the discharge rate for men was higher than the rate for women. Patients remaining on the intensive treatment service longer than two months included a substantially higher proportion of women.

In one hospital studied, state law required 90 days' hospitalization for alcoholics.

Disposition From the Intensive Treatment Service. Hospital policies influenced the disposition of patients. At the receiving hospital S-3, patients who did not respond within the time limit permitted were transferred to state hospitals.

Of the 8541 patients in the study, 41 per cent were discharged directly from the intensive treatment service to the community with variations between hospitals ranging from 17.3 per cent at S-4 to 79.9 per cent at S-2.

The rest of the patients were transferred from the intensive treatment service as follows to:

Continuous treatment service	16.3%
Geriatric service	11.6%
Convalescent service	10.5%
Medical and surgical service	8.5%
Chronic disturbed service	3.4%
Tuberculosis service	1.8%
Other hospitals	3.2%

Discharge by death occurred in 2.5 per cent of the 8541 patients and 1.3 per cent of the patients eloped.

Discharge rates showed a relation to diagnosis. The discharge rate for patients with senile psychosis and psychosis with cerebral arteriosclerosis was 9.6 per cent. The rate for schizophrenic disorders was 38.4 per cent, for alcoholics, 59.5 per cent, and for involutional melancholia, 63.5 per cent.

Present Status. At the time of the survey (January-June 1955) almost one-fourth of the patients admitted in 1953 were in the same hospital. An additional 2 per cent were known to be in other hospitals. The location of more than half of the patients (53.2 per cent) was unknown.

Suicides occurred in 20 cases (0.2 per cent) among the 8541 patients. They occurred among the younger and older patients alike and in a variety of diagnostic categories.

In addition to the suicides, 930 (10.9 per cent) patients were known to be deceased but the relation of death to the time of admission or discharge is not known. The senile and arteriosclerotic groups accounted for 629 (67.6 per cent) of the 930 deaths.

Discussion. Hospitals S-1, S-4, S-5 and S-6 were rather typical state hospitals. Hospital S-1 served also as a psychiatric observation center for the county in which it was located. Hospitals S-1 and S-6 were in densely populated states while S-4 and S-5 were in smaller states. Their per diem expenditure for each patient was in the $3 to $4 range, except for Hospital S-6, where the per diem expenditure was just over $2.

Hospital S-2, which was in the process of being activated to 1500 bed size, presented a somewhat atypical picture because of the policy which restricted admissions to those under the age of 45. Per diem cost was more than $8.

Hospital S-3 was atypical also since it was a receiving hospital. Admissions were restricted to those patients whose prognosis seemed favorable for short-term intensive care. This hospital had the highest rate of voluntary admissions among the six studied and the highest discharge rate. The per diem figure here was almost $8.

CHARACTERISTICS OF PRACTICE

The case record study of the admissions to these six state hospitals in 1953 revealed certain characteristics of the patients and of hospital practices. Except for Hospital S-3, a receiving hospital, patients entering these hospitals were usually committed. Patients with schizophrenia and alcoholism constituted about half the total admissions. The former were patients who usually remained for several months, whereas the latter left the hospital more quickly.

Most of these state hospital admissions were ambulatory. In view of this finding, the limited use of occupational, recreational and other activity

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therapies as shown in this study is surprising. It is possible that during the last three years, and especially since the tranquilizing drugs have come into more general use, this picture may have improved.

Electric shock therapy was a major therapeutic measure in these hospitals in 1953.

Close to a third of the patients left the intensive treatment service within a week after admission. The pressure of admissions as well as the ages and diagnoses of the patients may have influenced the rapid exodus. The schizophrenic patients tended to remain the longest on this service.

A 41 per cent discharge rate from the intensive treatment service back to the community is a creditable showing especially since a considerable number of admissions are elderly people with organic psychoses.

This study showed that nearly one-fourth of the admissions to these six state hospitals in 1953 were still patients in the same hospitals in 1955. If this figure is representative of state hospitals throughout the country, the need for additional beds each year may be rising at a high rate. A heartening note, however, is the recent reports that, with the use of tranquilizing drugs, more patients are leaving mental hospitals. (The New York commissioner of mental hygiene has reported 200 fewer patients in New York state hospitals in 1955 than during the previous year.)

Comment. This study of 11,000 psychiatric admissions to six general hospitals and six mental hospitals during the year 1953 is an initial step to determine the nature of psychiatric patient loads and treatment programs for psychiatric patients in general and state hospitals. This type of information is essential to the planning of physical facilities.

The study indicated the extent of information that could be obtained by examining case records and pointed out specific areas of information that the case records did not accurately provide.

These findings are offered for informational purposes. To the knowledge of the authors, no similar study on so large a scale has been reported in the past.

This is the second and concluding section of the case study of psychiatric admissions to general and state hospitals. The first section, covering admissions to general hospitals, appeared in the December 1956 issue of this magazine.

You Can't Afford Not to Have a Pharmacist

But if it just isn't possible, why not make an arrangement with the local retail pharmacist to serve the hospital, or employ a consultant?

GROVER C. BOWLES Jr.

EVERY hospital should have a pharmacist, but actually instituting pharmacy service in some hospitals is a fairly difficult task. About 60 to 70 per cent of the hospitals in this country are 100 beds or less in size, and the introduction of pharmacy service into these small hospitals is the prime concern now of hospital pharmacists. By and large, the hospitals of 100 beds or more are fairly well set as far as pharmacies are concerned. They can improve their departments a great deal—greater efficiency, more control, better operating technics.

SMALL HOSPITALS A PROBLEM

However the real problem of pharmacy service exists in hospitals of 100 beds or less. One approach to providing pharmaceutical service in the small hospital is to employ a full-time pharmacist. Most pharmacists agree that is the thing to do. The difficulty is that it has some limitations. One of the big limitations is to get the pharmacist to go into a small hospital and develop the job for himself. Some pharmacists are shortsighted. They don't see the potential of the department. It can be a fascinating job to work in a small hospital.

Another limitation is that the hospital administrator may not be convinced that it is good business to add a pharmacy. Some administrators who have agreed wholeheartedly to the idea of having a pharmacy still do not have pharmacists in their hospitals; in smaller communities where good public relations must be maintained there may be situations in which it just isn't expedient to employ a pharmacist in the hospital. A part-time pharmacist may be the best answer in many cases. A solution that would be ideal would be for one pharmacist to be employed by a group of four or five hospitals, with the pharmacist spending a day or a day and a half each week in each hospital. Of course, travel would be a problem. The hospitals would have to be within a radius of 50 miles, or at most 75 miles, because commuting between hospitals would become a major task. But it would be advantageous if hospitals which did not have full-time pharmacists had somebody coming in regularly one or two days a week to take care of purchases and ward stocks and routine drugs for the various departments, to keep up the inventory records on narcotics and alcohol, to advise the administrator on any pharmaceutical problems he might have, to consult with the medical staff and the nurses, and perhaps lecture to the nurses.

Such an arrangement is not entirely new to the hospital field, particularly in small hospitals around the country which have used pathologists and radiologists, or even laboratory technicians, on a shared basis. To my knowledge, however, it has not been done widely in pharmacies. In one New England group of hospitals, there is a pharmacy consultant, available by telephone or mail, but I believe he visits the hospitals only about once a year. That's hardly enough to do the job. If it could be done with a group of four or five hospitals joined together, it would not be a financial burden on any hospital and it certainly would seem worth while.

JOINT PURCHASING POSSIBLE

Ideally, a group of that type would do some joint purchasing. When you do group purchasing you run into trouble right away. Every unit wants to maintain its prerogative of specifying what it wishes to use. Doubts slip into the minds of some people as to whether one hospital is getting the best buy, or whether they are being penalized because they are in the group. Nevertheless, the way pharmaceuticals are priced, quantity usually is a consideration. The pharmacist in this case could buy in larger quantities than the hospitals would ordinarily use themselves. There could be some prepackaging done at a central location; some drugs might be bought 50,000 or 100,000 tablets at a time, and these lots broken down into bottles of 100 or 1000 or whatever was needed by individual hospitals. This would save some money, but the pitfall is that every hospital wants to maintain its identity and have the final say on purchases. So it takes a pharmacist who understands what he is trying to do and is effective at keeping everyone happy.

The hospital councils throughout the

Mr. Bowles is chief pharmacist of Baptist Memorial Hospital, Memphis, Tenn.

This article has been condensed and adapted by the author from a paper presented at the Mississippi Pharmacy Forum for Hospital Administrators sponsored by the Mississippi Hospital Association, Jackson, Miss., May 1956. This is the second and concluding section of Mr. Bowles' paper; the first section appeared in January.

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What Size Hospital Needs a Pharmacist?

During the pharmacy forum for hospital administrators sponsored by the Mississippi State Hospital Association, this question was asked of Reed B. Hogan, administrator of Coahoma County Hospital, Clarksdale, Miss. Following is his answer.

POSSIBLY the easiest way to approach that question would be to describe the conditions at one hospital that I am familiar with. In this 40 bed hospital, for many years the normal procedure for handling drugs was this: When the doctor wrote his orders, the nurse would pick up the phone and call the drugstore, the drugstore would deliver the medicine and charge it directly to the patient at the regular retail price. If the hospital ordered routine supplies — something like aspirin or that type of drug—the store would charge the hospital the retail price less 10 per cent. Obviously, there was a tremendous amount of money spent on drugs, when the hospital could have purchased the drugs at from 10 to 50 per cent cheaper than the drugstore could have in the first place!

I don't know any way to get at the exact figure, but I feel absolutely certain that a pharmacist in that 40 bed hospital could have saved his own salary—and probably the administrator's and the director of nurses', too, if he had been in the hospital purchasing and dispensing drugs!

The administrator and the board of trustees may feel that they cannot afford to pay a pharmacist, but at least they can go downtown and make arrangements with a local pharmacist to advise them.

For example, consider an item like tetracyclene. How many brands do we have? If I remember rightly there are at least seven or eight. In a hospital without a pharmacist you will probably find all eight brands, or seven. A pharmacist can cut that down to one, possibly, and certainly to no more than two or three. At about $20 a bottle that's a lot of money to have tied up on one little shelf, on one drug!

That is just one item out of several hundred. This doctor likes this brand, another likes another one, and in many small hospitals, especially, the staff organization is such that the administrator can't get a pharmacy committee to support the pharmacy. On a practical basis, however, the pharmacist is in a much better position to work up a good pharmacy committee. He has time to talk to the doctors; if you want to call it that, he can play politics with them and get a pharmacy committee that's effective where the administrator can't. Like most administrators, I'm afraid to handle a pharmacy; it's a terrific responsibility.

There are many items in the hospital that are not connected with the pharmacy that the pharmacist can help us with. I remember the case of one pharmacist who made up a bleach that we were paying a dollar a gallon for; he mixed the same bleach chemically for 17 cents. A ruling from the attorney general's office in Mississippi two or three years ago puts an entirely new slant on the need for pharmacies. I asked the attorney general three specific questions: (1) Does the state law require that a registered pharmacist supervise a hospital pharmacy? His answer: "I am of the opinion that the state law requires that a registered pharmacist supervise a hospital pharmacy unless the physicians prescribing medicines for their patients and the hospital actually compound their own prescriptions." (2) May a hospital without a registered pharmacist fill prescriptions for patients as they leave the hospital? The answer: "No." (3) What permits are necessary to operate the hospital pharmacy? The answer in this case wasn't clear, and we have not found out yet for sure. But it is clear that we can't afford to have even a single hospital without a pharmacy!

country will have to take the lead in this type of thing. In many areas they have provided consultants in medical records and dietary and nursing service, but rarely have they provided consultants in pharmacy. If the hospital cannot employ a full-time pharmacist or a part-time pharmacist, a pharmacy consultant can be a valuable asset. Ideally he should be a person with a broad background and have not only understanding of pharmacy operation but also of the total operation of the hospital. He would not necessarily have to visit the hospital frequently, but he should be available by telephone and the administrator should be able to correspond with him. There are many problems which are the same in hospitals all over the country and actually all over the world. The control of narcotics is a problem in every hospital. The control of charges and how to charge for certain types of medication; whether to use multiples, thousands or single dose ampules; the formulary problem; the pharmacy and therapeutics committee—all those are basic problems that every hospital in the country has. A well trained hospital pharmacist could serve as consultant to a rather large group of administrators. He should be compensated for his services. If a person is paid to do a job, he usually takes more interest in it than he does if he is doing it just for the good of the cause. From the hospital administrator's point of view, if he is paying for the service he feels a little more like imposing on the consultant, getting information from him, and demanding a certain amount of service.

Certainly, in the planning of hospital pharmacies consultants should be used, and there are a number of people in the country who are qualified to do consulting work in hospital pharmacy. Hospital architects are interested in being advised by people who know what type of department is needed, the number of square feet, what type of equipment, and what type of electrical lines should be installed. Too often, the pharmacist is consulted too late, after the concrete has been poured, and we find that there is no sink in the pharmacy and that there is no room for a refrigerator, or not adequate space for other needed equipment.

Another aspect of pharmacy service for small hospitals which is totally unexplored is the use of retail pharmacists. In almost every community of

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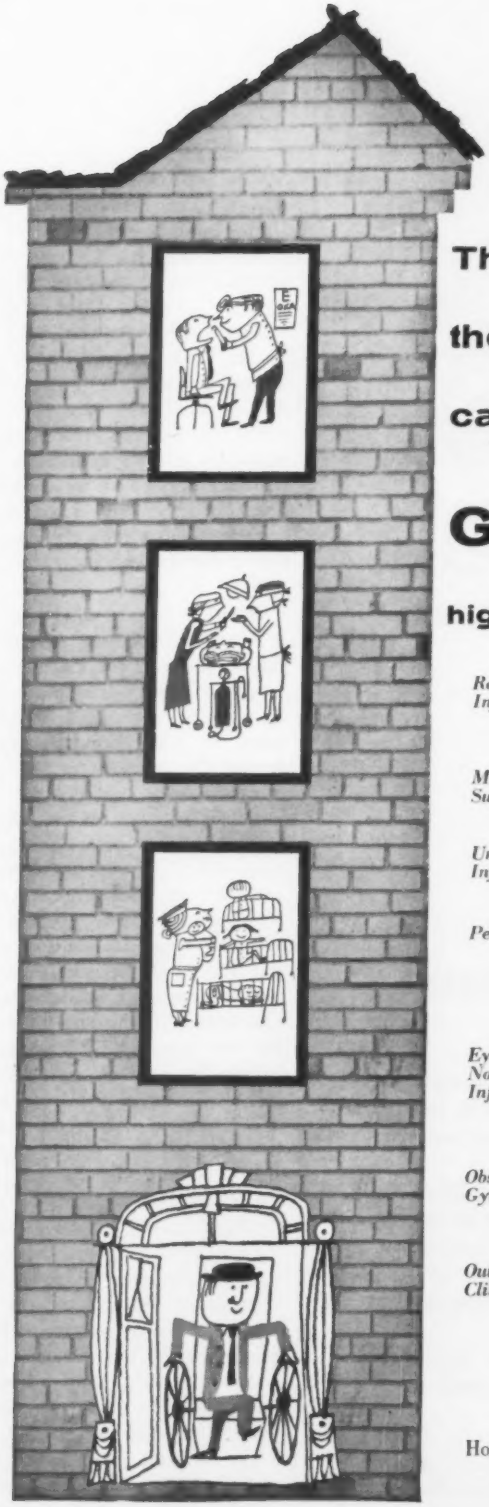
any size in the United States, there is a retail pharmacy, and we have a lot of small hospitals located in rural areas and suburban areas, and there is no reason in the world why a retail pharmacist can't do a job for the hospital. To accomplish this, someone is going to have to educate the retail pharmacist to the hospital's point of view. Too often—in 90 per cent of the cases, I should say—the retail pharmacist wants to fill the prescription, take the gravy, and not worry about the service. Probably there are two reasons for this. One is that the man just doesn't understand the complicated operation of the hospital and the actual pharmaceutical needs of the hospital, and, secondly, the retail pharmacist is in business. He has taxes to pay, he has a payroll to meet, he is pushed for time, and he wants to operate his store at maximum efficiency and get a fair return on his money.

For all these reasons, I think that hospitals negotiating with local retail pharmacists should seek to retain the pharmacist on a salary and not just buy everything through the drugstore and expect the pharmacist to take his compensation in profits. I believe it would be worth $100 a month, or possibly a couple of thousand dollars a year, to a hospital to have competent pharmaceutical service available. If the pharmacist were paid such a salary he might be available himself or if he is the owner make one of his pharmacists available for two or three hours a day to go to the hospital and provide the needed service. Certainly this should include more than just prescription service. It should include the labeling of stock containers for the floors, inspection of the drug cupboards, meeting with the pharmacy and therapeutics committee, advising on purchasing if he doesn't actually do it, control of narcotics and alcohol, and anything else that enters into the professional aspects of pharmacy operation.

Such an arrangement should not be made on a "cost plus" basis, however, in my opinion. An agreement with the local retailer that he will supply your pharmaceutical needs for his cost plus a percentage is unsound. In the first place, it is difficult to determine his cost. I have had an opportunity to check on some of these arrangements, and I know that it is impossible to control them when you study the prices they have charged. The hospital administrator doesn't know whether the man purchased in 5000, 10,000, or 100,000 lots, or whether he purchased the smallest container available, which may have been 50 tablets. The chances are good that his price has been based on the smallest commercial container available. Right away, that can cost the hospital a lot of money.

Another hazard is that the pharmacist may pad his bills occasionally. A monthly bill from a retail pharmacy to a hospital will amount to a considerable sum of money. There will be many entries and many charges, and it is an exacting task to check each invoice to the letter. I have great faith in pharmacy as a profession, and I believe that most pharmacists are basically honest people, but it's difficult for a man owning a store and operating a retail business to give the type of service a hospital needs unless he is educated to the hospital's point of view and unless, at the same time, the administrator and perhaps the hospital board can take this pharmacist into their confidence and sell him on the idea of giving a certain amount of community service. Once a retail pharmacist can be inspired to the point



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that he thinks he is doing a community service and is being compensated fairly for his services, he is more willing to accept a salary or retainer fee than a "cost plus" arrangement.

For example, one young pharmacist who has a professional prescription shop in Memphis has an agreement with the City-County Tuberculosis Hospital there. He goes to the hospital for an hour or so each morning; he receives his breakfast and I believe $100 a month for his services. He makes his calls early in the morning, around 7 o'clock, so it doesn't interfere with his business. He fills the ward baskets, labels whatever needs to be labeled, and performs other needed professional services. Since this is a tax supported institution, everything is bought on bid, and the visiting pharmacist has nothing to do with the purchasing except to advise and help with specifications. This arrangement has been in effect for two or three years, and it has worked out quite successfully.

When a new hospital was opened in Memphis not long ago, this same young pharmacist called on the administrator and board and sold them on the idea of paying him a monthly salary to give them pharmaceutical service. He goes to the hospital at a certain time every day; some days, it's less than an hour, and it rarely averages more than an hour. Again, he takes care of the ward containers, issues narcotics, and in general keeps the pharmaceutical service of the hospital in good shape. In addition, the medical staff and the administrator can contact him any time they want to by telephone. This arrangement is good for the pharmacist's business, and I believe the hospitals are getting a fine service. If retail pharmacists can be educated to the point of view of the hospital, that may be the solution for pharmaceutical service for a great many small hospitals.

Unfortunately, through the years there has been some friction between retail pharmacists and hospital pharmacists. In nine out of ten cases it has been due to ignorance. The retail pharmacist thinks the hospital pharmacist is trying to put him out of business. The hospital pharmacist thinks the retail pharmacist has got it in for him and wants to cut his throat any time he gets a chance. If the two parties would get together and talk over their problems, there would be no conflict at all!

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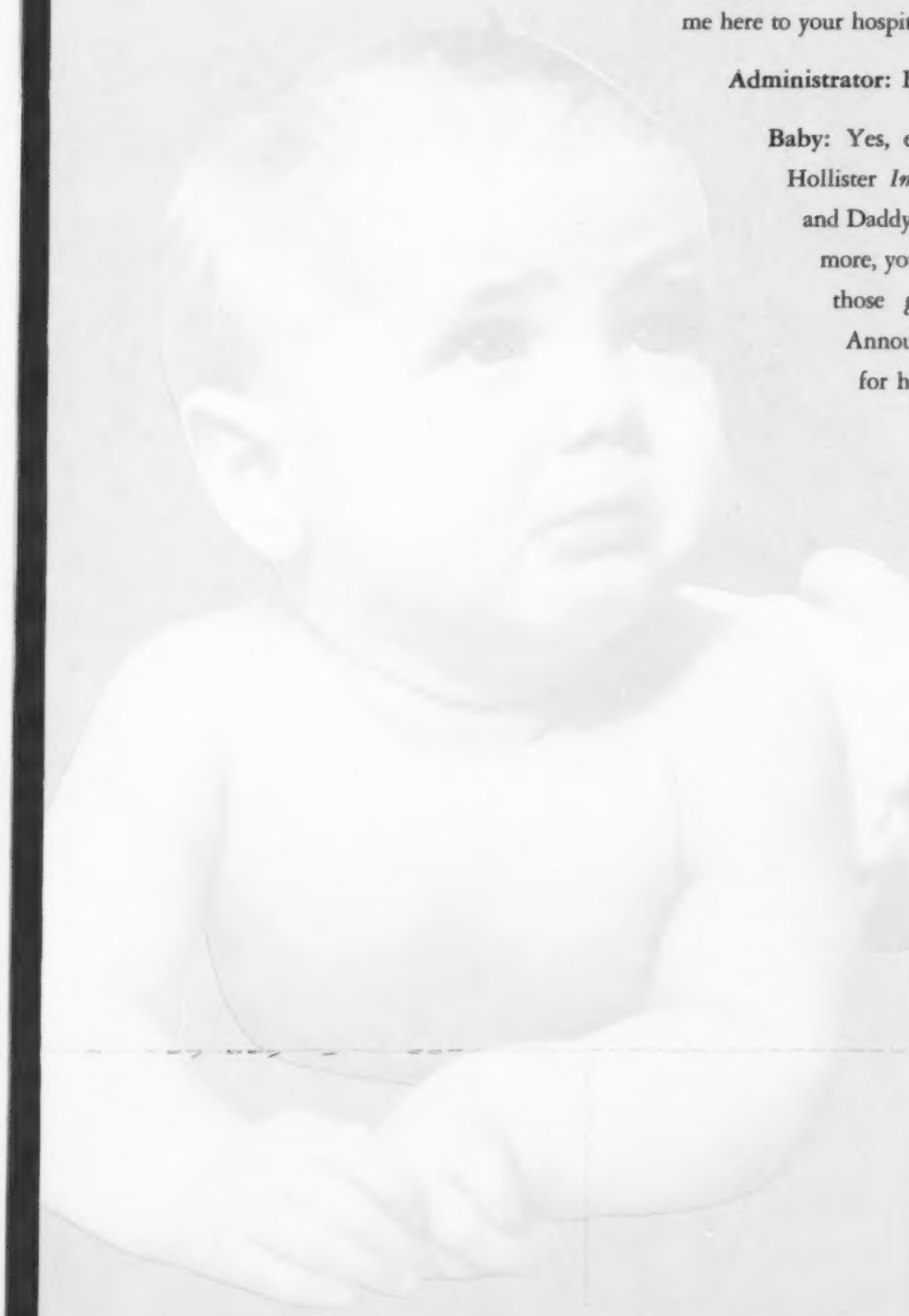

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How to Select a Food Service System

These questions and answers are designed to aid in the selection of the food service system that will provide the best food and the best service to patients at the lowest cost to the hospital

LOUISE A. K. FROLICH

IS THE patient's meal important? A recent survey of hospital patients by Opinion Research Corporation of Princeton, N.J., showed that patients thought food and nursing care more important than medical and surgical care. The importance of food in the treatment of the patient is an established fact. An attractively served tray can stimulate and encourage the patient to eat. Therefore, the service of the food to the patient may be considered the keynote of the whole food service operation.

Selection of the food service system that will provide the patient with the best food and service involves an important decision for both hospital administrator and dietitian. This system must not only fit into the over-all operation of the food service department, but it must also be coordinated with the operation of the hospital as a whole.

IT'S A COSTLY SERVICE

Because the food service department utilizes from 20 to 25 per cent of the hospital budget, the initial expense of the equipment, the cost of upkeep and replacement are important. The ease of operation of the equipment and effective utilization of personnel are important not only from the cost aspect but also for employe cooperation in properly using the system. Of course, the service provided by the manufacturer of the equipment in planning the layout and in setting up the operation of the system cannot be overlooked. Therefore, anyone who is selecting a food service system should ask these questions:

1. *Will the system provide the patient with the best food possible?* When selecting a food service system the most important factor to consider is the patient himself. What does he expect from food service in the hospital? Too often, justly or unjustly, the food set before the patient is the criterion used in judging the reputation of the hospital.

In order to provide the patient with meals he will enjoy and not just eat, the food that is served needs to be at the proper temperature; it needs to be attractive and fresh looking and, most important, it needs to be the food he selected from the menu or that which is prescribed for him. The tray should be neat and orderly, liquid foods should not be spilled, and the plate covers used to keep the food warm should not be difficult to manage. There should be no evidence of transfer of food flavors or odors. Good, hot coffee is an absolute "must" in patient food service.

To assure the patient of this type of service, the food service system should be so constructed as to provide for temperature control of both hot and cold food, and it should provide facilities for handling difficult-to-serve items, such as bacon, toast and ice cream. The final assembling of hot and cold foods on the patient's tray should be accomplished without error. Facilities for handling delayed trays, last minute diet changes, or last minute admissions are important in a good food service system.

2. *Will the system be easy to supervise and control?* In all commercial food service operations, *i.e.* restaurants or cafeterias, close supervision of the food serving determines success or failure of the operation. The attractively served plate or tray increases customer satisfaction and encourages return trade. Accurate filling of the order for food and serving portions of correct size mean the difference between financial success and failure in any food service operation.

Likewise, the supervision and control of the service of food is important in a hospital. Too often this is not as efficient as it might be because the food service system is spread over too large an area of the hospital and because of the shortage of dietitians and trained food service personnel to supervise the operation.

BETTER USE OF SUPERVISORS

A food service system that permits the setting up and serving of trays close to the preparation area will allow for better utilization of the supervisors in that their activities will be more concentrated. Closer supervision of the serving operation will in turn permit a more accurate control of the production of foods, for both the regular and the modified diets. Costs can be controlled by cutting down on overproduction of foods. Closer supervision

At the time this article was prepared, Miss Frolich was senior home economist for the Midwest Research Institute, Kansas City, Mo.

of the serving of patient trays will permit better control over accuracy and neatness. Thus, it is important, when selecting a food service system, to choose one that will permit close supervision of the operation with a minimum of effort and cost.

3. *Will the system permit efficient utilization of the dietary personnel?* The food service system should be so planned and constructed as to permit the workload of the employes to be fairly even and constant throughout the day, and not one that has two or three periods of great activity and several periods of slack time.

An even flow of work will eliminate need for duplication of personnel to take care of the noon hour rush and allow the work to be spread over a longer period of time, thus permitting the same employes to perform more than one task.

4. *Is it a low cost system?* In determining the cost of a food service system, consideration must be given not only to the initial outlay for the equipment and system but also to the rent (amount of floor space occupied by the system), the cost of the personnel involved in the efficient operation of the system, and the cost and amount of repair and maintenance required by the system.

RETURN WOULD BE INADEQUATE

Four dollars is a reasonable figure established to determine the cost of rent for 1 square foot of floor space per year. A system that requires floor space in many areas of the hospital could prove to be costly. This would be especially true if the space is not fully utilized throughout the day, but is used only during the meal hours. From a business point of view, this type of system would not give an adequate return on the investment.

A system that requires the use of floor kitchens or serving pantries usually requires a duplication of permanently installed equipment. How often and for how many hours a day is this equipment used? Again, is adequate value received for the investment made on the equipment?

Labor is an important factor in the selection of a food service system. A system that permits the concentration of its activities in adjacent areas is far more economical laborwise than one that requires many serving areas and much duplication of labor and supervision. In determining the cost of employes who take part in the serving of the food, it is not only the wages paid the food service personnel that must be considered, but also the time and wages of the employes from other departments who may be called upon to help serve the food to the patients.

WILL PAY FOR ITSELF

Therefore, an economical food service system is one that will pay for itself by better utilization of labor, by better utilization of floor space, by reduction in duplication of permanently installed equipment, and by increased patient satisfaction.

5. *Is the system flexible and easily adaptable to present food service departments?* The rapid increase in bed capacity in hospitals in the last decade has caused many departments within the hospital to be concerned about their inability to cope with the situation. Not the least of these is the food service department. With the increase in patient load, the need for an efficient and expedient system of serving food to patients in the same length of time without additional work areas has created a critical problem. All too often the system presently used cannot accommodate the increased load.

Therefore, it is important when planning a food service system to select one that is flexible and will fit in with the present facilities, permit expansion without undue expense, and permit utilization of modular equipment. The system should be adaptable to the routine established in the kitchen but not so complicated that the employes find it difficult to use. The system needs to be concentrated so that the supervisor does not have to spread her activities over too great an area to keep up with the food service procedures. It should not be dependent upon the help of employes from other departments in the hospital to complete the service to the patient.

6. *Does the manufacturer provide assistance in planning and installing the system?* Food service equipment is expensive. Before the dietitian submits a request for the purchase of equipment, she has given much thought to the need for the particular equipment in her food service operation and feels that the type she selected will do the job.

A food service system is a long-term investment. Because of this, many factors need to be considered before a selection is made. Both the physical layout of the food service department and of the hospital need to be considered. The administrator and chief nurse both are vitally interested in the system that is to be selected from the point of view of the service it gives the patient as well as the way it will fit into the hospital routine. The administrator certainly is concerned with the cost of the system. Therefore, much planning must be done before the selection can be made.

Does the manufacturer of the food service system in which you are interested provide advisory service in the planning stages? Many manufacturers offer a service to hospitals in planning most effective use of the equipment and, after installation, help to train the personnel in the use of the new system. In other words, the manufacturer should be concerned with follow-through on his system by reviewing the food service periodically and keeping the dietitian advised of the latest improvements. Local and factory assistance and service should continue after installation if it is needed.

7. *Is the system easy to operate, maintain and clean?* The success or failure of a food service system is dependent upon the ease of operation, maintenance and cleaning. The system should be so organized as to permit the work procedure to be learned easily and followed by the employes. The equipment should not be awkward or heavy to handle.

KEEP BREAKDOWN TO A MINIMUM

It is important that the system be mechanically efficient. Frequent mechanical failure which may cause a major breakdown in the entire system could be costly. These failures could also cause undue inconvenience to the patient and the hospital as a whole.

The layout of the system should permit housekeeping to be accomplished with a minimum of time and effort by the food service employes.

The prime purpose of a hospital food service system is to provide the proper food to the patient in an attractive and appetizing manner. To accomplish this, the system selected should be easy to supervise and control, permit efficient utilization of the dietary personnel, be low in cost, be flexible and easily adapted to the present facilities, and be easy to operate and maintain. The manufacturers should assist in planning the layout, installing the system and training the employes, as well as provide follow-up service on the correct use of the system.

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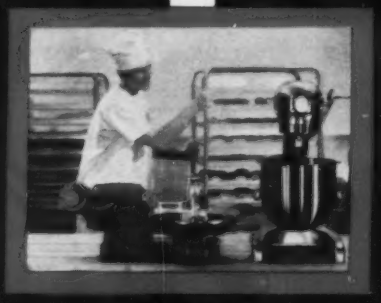

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FOOD FOR THOUGHT

Young Chickens

An oven-barbecue is a colorful, flavorful and thrifty way to cook young chicken. Cooking takes about an hour. Use a slow oven to allow the barbecue sauce to flavor the chicken and also to prevent scorching. For four or five servings, buy a 3 to 3½ pound cut-up chicken. Pour barbecue sauce over the chicken in a baking pan, cover pan, and bake 45 minutes at 325°F. When meat is tender, uncover the pan and place under the broiler to brown. Allow about 15 minutes and watch carefully to avoid scorching. Ingredients for the barbecue sauce are: 2 tablespoons brown sugar; 1 tablespoon paprika; 1 teaspoon salt; 1 teaspoon dry mustard; ¼ teaspoon chili powder; few grains cayenne pepper; 2 tablespoons Worcestershire sauce; 1 cup tomato juice; ¼ cup chili sauce or ketchup; ¼ cup vinegar; ½ cup chopped onion. Mix and cook over low heat 15 minutes before pouring over the chicken.

Mashed Potatoes

Have you ever taken a popularity poll of potato dishes? Indications are that mashed potatoes will get honorable mention or better, especially at meals where there's plenty of meat or poultry gravy to go along. Surveys among consumers show that mashed potatoes are among the top favorites. In one survey they took the lead, according to the U. S. Department of Agriculture.

Often plain boiled potatoes are served routinely because cooks feel that it's difficult to make good mashed potatoes or it takes too much time. Cookery specialists offer some tips on making mashed potatoes at their best —smooth, creamy white, fluffy, mealy and with good natural potato flavor. They say successful mashing can be done in just a few minutes if you have the knowledge.

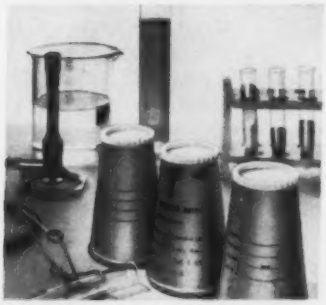
Begin with hot, freshly cooked, peeled potatoes. (Warmed-up, leftover potatoes won't do because they'll be too firm.) Be sure potatoes are not overcooked so that they are broken or "waterlogged," yet are cooked tender all the way through. Hot tender cooked potatoes can be beaten up fast with an electric beater. Or use a hand masher. The important point is to work fast and keep the potatoes hot. If you have to transfer the potatoes from one container to another, have the containers hot. As you mash or beat, add *hot* milk gradually — just enough to make the potatoes smooth and fluffy. Also add salt, pepper, and butter or margarine. Mashed just before serving and served piping hot, they'll be at their best.

Freezing Meat

Many inquiries about freezing meat are received by the U.S. Department of Agriculture. Specialists say the chief advantage of freezing, especially for those who purchase meat, is the convenience of having a variety of meats on hand. But often money can be saved if meat is bought when prices are down seasonally.

Buying meat for the freezer. When cutting and packaging meat, remember that sanitation is important. This means clean hands, clean cutting place

SANITATION IS JUST ONE GOOD REASON



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and tools, and clean wrappings, so meat won't go into the freezer carrying a load of bacteria that may increase rapidly when the meat is taken out and thawed. Freezing does not kill all bacteria that cause spoilage or affect the flavor of meat.

Packaging. Meat for freezing must be tightly wrapped and securely sealed in moisture-vapor-resistant wrappings. Satisfactory wrapping materials include: metal "freezer foil," various plastic or synthetic films or bags, and special heavily waxed paper made for freezing. Press the wrapping close to the meat before sealing to drive out as much air as possible. Label each package with the name of the meat, the cut, date when frozen, and quantity in the package. Meat that has been frozen and thawed keeps satisfactorily two or three days in the refrigerator. It's even possible to refreeze it, provided it is in good condition for fresh eating when it goes back into the freezer.

Loading the freezer. To prevent loss of quality or even spoilage, it's important to know how much meat to freeze at a time and how to place it for rapid freezing. The manufacturer's directions that come with the freezer usually tell the maximum freezing load for the particular freezer and also tell where and how to place food. Generally, the load should not exceed 1/15 or, at most, 1/10 of the total capacity of the freezer at a time. This is to guard against too slow freezing. For quickest possible freezing, each package should be in direct contact with a refrigerated surface. If the packages are massed together, those at the center may not freeze fast enough to keep meat from spoiling. Leave a little space between packages for circulation of air that hastens the freezing.

How long to store. All meats—beef, veal, lamb and pork—keep well in the freezer if properly wrapped and stored at 0° F. or lower. Fresh pork products are best if kept in the freezer not more than six months. Beef and lamb may be kept longer—from 9 to 12 months. In response to questions about aging meat before freezing, the specialists say there is little advantage in having beef or veal aged more than 10 to 14 days before freezing. Veal and pork should be frozen as soon as possible after slaughter — certainly within a week. The least satisfactory meats for freezing are pork sausage and cured pork products, particularly sliced bacon. These should not be kept in the freezer longer than 3 months. The salt hastens the development of rancidity of the fat, and makes the meat less palatable.

Keeping Milk

That fluid milk should be kept cold and closely covered seems like a fact too well known to deserve mention. A study of the keeping quality of bottled pasteurized milk by the West Virginia Experiment Station indicates otherwise. For good flavor, milk should go into the refrigerator promptly after delivery, and be taken out only to pour out milk for immediate use and then put back with cover firmly in place. Cold keeping holds down increase of bacteria and acid in milk; close covering prevents milk from absorbing off-flavors.

The station reports that bottled pasteurized milk, properly kept, has good flavor up to three or four days after delivery but changes rapidly to poor flavor after five to six days. This finding shows that delivery every other day or three times a week is satisfactory for good pasteurized milk, if both milkman and customer use care.

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Menus for March 1957

Barbara L. Awrey
Administrative Dietitian
Jennings Memorial Hospital
Detroit

1 Grapefruit Sections Scrambled Eggs • Clam Chowder Lobster Newburg in Tart Shell Fresh Fruit Salad, Celery Seed Dressing Butterscotch Square, Topping • Baked Stuffed Whitefish Escalloped Potatoes Stewed Tomatoes Cabbage Slaw Cream Puff	**2** Tomato Juice Bacon, Roll • Barley Soup Creamed Chipped Beef on Melba Toast Apple, Date, Celery Salad Apricot Whip • Breaded Veal Chop, Spiced Fruit Parsley Buttered Potato Glazed Carrots Kidney Bean Salad Pumpkin Pie, Topping	**3** Orange Juice Soft Cooked Egg • Fried Chicken, Cranberries Mashed Potato, Gravy Buttered Asparagus Grapefruit & Avocado Salad, French Dressing Strawberry Sundae • Navy Bean Soup Tomato Aspic Ring Stuffed With Egg Salad Potato Chips, Spiced Fruit, Relishes Banana Bread, Butter Angel Cake, Orange Icing	**4** Stewed Apricots Canadian Bacon • Chicken Gumbo Soup Chop Suey on Rice Carrot and Raisin Salad Orange Bread Pudding • Roast Sirloin of Beef Oven Browned Potato Gravy Brussels Sprouts With Chopped Almonds Peach with Cream Cheese, Dates and Nuts Apple Pie, Cheese	**5** Grapefruit Juice Poached Egg, Toast • Vegetable Soup Chicken à la King on Biscuit Chef's Salad, Oil and Vinegar Dressing Chocolate Fudge Pudding, Topping • Calves Liver, Bacon Hashed Brown Potatoes Buttered Mixed Vegetables Orange and Grapefruit Sections, French Dressing Pumpkin Cake, Fluffy Icing	**6** Orange Juice Soft Cooked Egg, Doughnut • Cream of Asparagus Soup Hamburger on Bun Spinach and Tomato Salad, Garlic Dressing Baked Pear, Topping • Roast Veal, Spiced Fruit Mashed Potato, Gravy Green Beans, Mushrooms Fruit Salad, Celery Seed Dressing Butter Pecan Ice Cream
7 Stewed Prunes Pancakes, Sirup • Corn Chowder Ham Croquettes With Horseradish Sauce Relish Plate Chocolate Chip Cookies • Baked Stuffed Pork Chop, Applesauce Parsley Buttered Potato Buttered Lima Beans Jellied Bing Cherry and Nut Salad, Mayonnaise Lemon Meringue Pudding	**8** Grapefruit Sections Scrambled Eggs, Roll • Oyster Stew, Crackers Macaroni and Cheese Pineapple, Marshmallow and Cabbage Salad Apple Crisp, Topping • Scallops, Tartare Sauce Baked Potato, Butter Harvard Beets Pear & Cream Cheese Balls With Nuts Banana Cake, Fluffy Icing	**9** Tomato Juice Bacon, Toast • Peanut Soup Eggs Benedict Grape Waldorf Salad Butterscotch Nut Pudding • Roast Leg of Lamb, Mint Jelly Buttered Wax Beans Stuffed Celery Salad Caramel Pecan Pie	**10** Orange Juice Hot Coffee Cake • Consommé Tenderloin Steak, Steak Sauce Baked Potato, Butter Buttered Peas Chef's Salad, Blue Cheese Dressing Caramel Fudge Sundae • Split Pea Soup Bacon and Tomato Sandwich With Cheese Sauce Fresh Fruit Salad With Celery Seed Dressing Chocolate Cake	**11** Stewed Prunes Poached Egg, Toast • Washington Chowder Chicken Croquette, Mushroom Sauce Marinated Green Bean Salad Lemon Sponge Pudding • Baked Ham, Raisin Sauce Candied Sweet Potato Corn O'Brien Jellied Carrot and Pineapple Salad With Mayonnaise Blueberry Pie	**12** Grapefruit Juice Link Sausage • Barley Soup Tenderloin Tips on Toast Sliced Orange, Coconut Salad Cherry Cobbler • Broiled Breast of Chicken Cranberry Jelly Whipped Potato, Butter Buttered Asparagus Pear With Grated Cheese, Mayonnaise White Cake With Coconut Icing
13 Orange Juice Soft Cooked Egg, Toast • Cream of Celery Soup Lamb Stew Spinach & Tomato Salad, Garlic Dressing Baked Apple With Marshmallow • Roast Sirloin of Beef Oven Browned Potato Cauliflower au Gratin Head Lettuce, 1000 Island Dressing Chocolate Chip Ice Cream	**14** Stewed Prunes Bacon, Sweet Roll • French Onion Soup, Croutons Chicken Pie Grapefruit and Apple Salad, French Dressing Gingerbread, Topping • Calves Liver, Bacon Baked Potato, Butter Broccoli, Lemon Butter Molded Cucumber Salad Lemon Pie	**15** Grapefruit Sections French Toast, Sirup • Potato Chowder Crabmeat Lorenzo in Bread Cup Carrot and Raisin Salad Prune Whip • Salmon Steak, Lemon Creamed Potatoes Stewed Tomatoes Pickled Beet & Hard Cooked Egg Salad Date Torte, Topping	**16** Tomato Juice Bacon, Doughnut • Chicken Noodle Soup Poached Egg on Corned Beef Hash Chef's Salad With French Dressing Broiled Grapefruit With Sherry • Tenderloin Steak French Fried Potatoes Buttered Mixed Vegetables Banana Nut Salad Apple Pie and Cheese	**17** Orange Juice Raisin Bran Muffins • Consommé Madrilene Roast Turkey, Cranberries Dressing, Giblet Gravy Mashed Potatoes Buttered Peas Grapefruit and Avocado Salad, French Dressing Chocolate Sundae • Ministrone Soup Creamed Chipped Beef on Toast Relish Plate Graham Cracker Cake	**18** Stewed Apricots Poached Egg, Toast • Turkey Gumbo Soup Grilled Cheese Sandwich Dill Pickle Slices Apple, Date and Celery Salad Vanilla Custard • Baked Ham, Raisin Sauce Baked Sweet Potato Green Beans and Mushrooms Ribbon Salad Cherry Pie
19 Grapefruit Juice Link Sausage • Cream of Tomato Soup Chop Suey on Rice Pineapple, Celery and Pecan Salad Tapioca Pudding With Sliced Orange • Fried Chicken Cranberries Mashed Potato, Gravy Glazed Carrots Canned Fruit Salad, Whipped Cream Dressing Applesauce Cake With Lemon Icing	**20** Orange Juice Soft Cooked Egg, Toast • Cream of Chicken Soup Swedish Meat Balls Peach, Cream Cheese, Date and Nut Salad Fudge Square, Topping • Roast Pork Loin Applesauce Oven Browned Potato, Gravy Brussels Sprouts Head Lettuce, Blue Cheese Dressing Strawberry Ice Cream	**21** Stewed Prunes Canadian Bacon • French Onion Soup, Croutons Cube Steak on Toast, Pan Gravy Sliced Tomato Salad, French Dressing Raisin Rice Pudding, Topping • Lamb Chop, Mint Jelly Baked Potato, Butter Buttered Corn Jade Salad Maple Pecan Pie	**22** Grapefruit Sections Scrambled Eggs • Clam Chowder Tuna Salad Sandwich, Sweet Pickles Fresh Fruit Salad, Celery Seed Dressing Sand Bar Cookies • Fillet of Sole, Tartare Sauce Escalloped Potatoes Spinach, Lemon Cabbage Slaw Pineapple Nut Torte, Topping	**23** Tomato Juice Bacon, Toast • Washington Chowder Beef Stew Stuffed Prune Salad Gingerbread, Topping • Breaded Veal Chop Spiced Fruit Parsley Buttered Potato Broccoli, Lemon Butter Relish Plate Butterscotch Pie	**24** Orange Juice Blueberry Muffins • Half Broiler, Cranberries Mashed Potato Giblet Gravy Buttered Squash Grapefruit and Orange Sections, French Dressing Strawberry Sundae • Navy Bean Soup Ham Sandwich Pineapple With Cottage Cheese Orange Raisin Cake
25 Stewed Apricots Poached Egg, Toast • Chicken Gumbo Soup Escalloped Ham and Egg Casserole Waldorf Salad Vanilla Pudding, Jelly • Roast Sirloin of Beef Oven Browned Potato, Gravy Creamed Chopped Spinach With Nutmeg Sliced Tomato With Pepper Ring, French Dressing Peach Pie	**26** Grapefruit Juice Link Sausage, Toast • Vegetable Soup Corned Beef and Cabbage Pear With Grated Cheese, Mayonnaise Oatmeal Cookies • Calves Liver, Bacon Hashed Brown Potatoes Buttered Mixed Vegetables Pickled Beet Salad Fruit Gelatin, Topping	**27** Orange Juice Soft Cooked Egg, Toast • Cream of Asparagus Soup Pastie With Gravy Spinach and Tomato Salad, Garlic Dressing Chocolate Pudding, Topping • Swiss Steak, Mushrooms Whipped Potato, Butter Carrots and Peas Head Lettuce, 1000 Island Dressing Coffee Ice Cream	**28** Stewed Prunes Pancakes, Sirup • Corn Chowder Chicken Salad Sandwich Dill Pickle Slices Peach With Cottage Cheese Pineapple Refrigerator Cake • Pork Tenderloin Applesauce Parsley Buttered Potato Cauliflower au Gratin Chef's Salad, Oil and Vinegar Dressing Chocolate Éclair	**29** Sliced Oranges Poached Egg • Cream of Potato Soup Shrimp Creole on Rice Fruit Salad Blueberry Pudding With Lemon Sauce • Fried Perch, Tartare Sauce Creamed Potato Buttered Beets Stuffed Celery Salad Spice Cake	**30** Tomato Juice Bacon, Toast • Chicken Rice Soup Ham Loaf, Horseradish Sauce Waldorf Salad Coffee Tapioca • Roast Lamb, Mint Jelly Mashed Potato, Gravy Buttered Asparagus Marinated Green Bean Salad Apple Brown Betty
31 Orange Juice, Hot Coffee Cake • Consommé, Tenderloin Steak, Steak Sauce, Baked Potato, Buttered Peas, Sliced Tomato and Avocado Salad, French Dressing, Peach Sundae • Split Pea Soup, Tomato Aspic With Chicken Salad, Relishes and Potato Chips, Bran Muffins, Chocolate Cake, Fudge Icing Ready-to-eat or cooked cereals served on all breakfast menus.					

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BEVERAGE DISPENSER

Exclusive Ideal built-in beverage dispensers feature individual thermostatic control. Thoroughly insulated from each other and from the remainder of the cart, they can carry both hot and cold liquids. Each well has 5½ quart capacity.

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Model 9020BC

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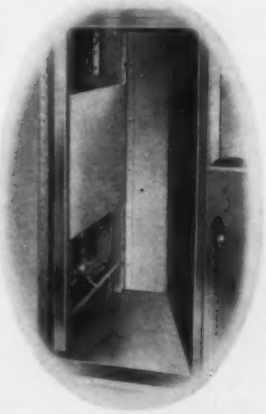
Exclusive Ideal overlapping doors provide positive seal regardless of temperature extremes. Easy to open and close. Glass fiber insulation reduces temperature change inside compartments.



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REFLECTIONS ON HOSPITAL LIGHTING

2. LIGHTING CORRIDORS

HOWARD HAYNES and K. A. STALEY

HOSPITAL corridors are used every hour of the day and night as working space for nurses and doctors. They are in daytime use constantly for nurse, doctor and patient traffic of all kinds. They are used by the staff members accompanied by wheel stretchers and dollies, as they go about their work of distributing food, laundry and medical supplies, and by housekeeping employes in their morning cleaning operations. In the crowded hospital today (we found none that weren't crowded), you find doctors signing reports, answering telephone calls, discussing operating technics with others on the staff, writing reports, prescriptions, and other minutiae demanding good seeing, all these in a so-called corridor.

Accordingly, the real requisites for hospital corridor lighting are much more demanding than they are for corridors as usually conceived in any other public building. Hence, the lighting system must be geared to high-scale visual demands and not just for "ordinary" daytime traffic.

In general, the lighting system should be designed so that the illumination is relatively uniform. If the luminaires are not continuous, the light should be so well distributed that it does not fall off more than 20 per cent between luminaires. It is also best to have a system of lighting which illuminates the ceiling surfaces reasonably well so that the contrast between the lighting equipment and its surroundings is not excessive. Brightness of the luminaires employed should be studied for their actual appearance in the ceiling. The color of the ceiling and upper side walls is significant also; if these are light in tone, the contrast between the luminaire and its immediate surroundings is desirably reduced.

Light walls and floors also have a material place in the over-all design. (Time was when dark walls were the rule, in order to conceal scuff marks made by wheel stretchers or other sources.) Today, the effective significance of the light walls has been realized by decorators and their most important contribution is that, if they are light in tone, they *keep light in circulation.* (Dark walls absorb light, so that it doesn't bounce to other surfaces at all but soaks in and is largely lost.)

Luminaires should be placed in a hospital corridor so that they are not glaring to patients through room doorways or transoms. As a rule, this point can be observed by choosing a luminaire that has either low candlepower in the direction of the room door, or

Main floor corridors have extra traffic. Exceptional lighting is needed in handling it. Here two systems are employed: downlights for general lighting plus the central indirect trough that is designed to lift the ceiling brightness.

This is the second in a series of articles on hospital lighting. The first appeared in January. The authors are application engineers in General Electric's Nela Park lamp and lighting headquarters in East Cleveland. They have been gathering the material for the last three years. The MODERN HOSPITAL is presenting the articles serially as reference aids to the hospital architect, designer, consulting engineer, administrator or departmental executive who is planning new space or the relighting and redecorating of existing space.

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one that can be shielded in that direction. This is a critical point; the sight lines should be carefully studied. Most luminaire manufacturers can supply *brightness* (not candlepower) distribution curves of their luminaires. The best way to judge this phase of selection is in a full-scale mockup of the corridor.

Shielding of long luminaires in corridors is easily accomplished on the direction of the axis of corridor. It is somewhat more difficult, however, in a crosswise direction. The best corridor lighting luminaires have the advantages of supplying light on the ceiling and upper side walls, again to relieve brightness contrasts. Light walls *and floors* help materially in adding brightness to walls and ceilings. Wall lighting in corridors is more significant than designers usually suppose.

SEEING SURFACES VERTICAL

The surfaces of [seeing] concern in a hospital corridor are, for the most part, vertical ones. We see people and objects along a long space, like a corridor, by viewing their vertical surfaces, not horizontal ones. The effective lighting system, therefore, is one which supplies considerable horizontal light. This can be obtained directly by luminaires which have high-side brightness, but as soon as this reasoning is adopted, the glare from the fixture defeats vision, rather than helps it. Only in very high ceilinged corridors is the high-side brightness luminaire usable. In the contemporary building, high ceilinged corridors are rare.

One excellent answer is illustrated here. The corridor is lighted from continuous luminaires along the walls, on both sides. The brightnesses involved are surprising; within reasonable limits, it can be said that *the ceiling and the floor have the same brightness.* (Actually the floor is 16 footlamberts, and the ceiling, 19 fL. The wall ranges from 14 to 75 fL.)

CEILING REFLECTS LIGHT

Another method, somewhat less comfortable visually, is the cove method, also illustrated. In one variation, the cove is on one side of the corridor. The ceiling is the principal light source by reflection. The ceiling is relatively bright, and this may account for a less comfortable effect than other methods. It is much more satisfactory than individual downlights, however, as shown in other examples. Any continuous source is inherently better than a discontinuous one, other things being equal.

The sameness of lighting and the resulting brightness pattern may be relieved periodically in a long corridor space by accent lighting. This is a surefire method. The method of accent may also include the use of furniture, such as a bulletin board, or a floral or other simple decorative ensemble. Some hospitals build in simple "wall desks" for occasional use by patients and personnel. The desks are not more than a foot wide, but they serve a dual purpose—utility and decoration.

When individual lights are used for corridors, they should be spaced rather close together. For reasonably uniform lighting, the Illuminating Engineering Society Handbook and other authorities agree that the spacing-for-uniform-lighting ratio should be in the neighborhood of 0.7 MH. This means that the distance between luminaires should not exceed 0.7 times their mounting height (height above the floor). (For a 9 foot ceiling, this would signify a spacing of 6 feet 4 inches.) The spread types can be spaced 0.9 MH for similarly uniform lighting. Distributions of recessed downlights vary widely; manufacturers' utilization data should be consulted before the final design is approved.

Hospital corridors which appear to be reasonably well lighted by day are often not so well lighted at night. The principal reason lies in the character of daylight which enters through the windows. The light from the sun and sky everybody enjoys; a bright, sunshiny day lifts all spirits. Sun and skylight diffuse the shadows, reduce the glare from light fixtures, and add "softening" light to the surfaces of walls and floors and furnishings. A brightness

By spacing luminaires more closely, the lighting designer can build up the light at elevators. Here troffers are installed in banks of three, which triples the lighting level.

About 10 footcandles of completely uniform lighting characterizes this corridor. It is lighted by a continuous cove containing overlapping 30 watt fluorescent lamps.

This corridor lighting "laboratory" in the Application Engineering Building at Nela Park is used to demonstrate modern technics in corridor lighting.

This corridor is done in light tones with luminaires along both walls. Continuous troffers of 40 watt lamps in reflectors are shielded by plastic louvers.

A lighted bulletin board in a corridor is easier to read and it stands a better chance of being noticed by busy people than an unlighted one does. Here, the 40 watt continuous fluorescent luminaire produces 100 footcandles at the top, about half the amount at the bottom of the board.

pattern is achieved that is much more acceptable to the eye than is ever achieved after dark, except in the most carefully designed contemporary structures.

For these reasons, the methods of illumination used in hospital corridors need to have more critical study than those for buildings principally used during daylight hours, such as office buildings. A sort of compromise solution is to reduce the general illumination at night. This generally (not always) reduces the brightness effect of the fixtures. In incandescent luminaires, this is accomplished by using two or more lamps in each luminaire or lamps with two filaments in each bulb. (These are the "three-light" lamps.)

A new method for fluorescent systems, devised by Del Kershaw of Nela Park, is to dim the fluorescent lamps. Such dimming is termed "continuous" or "infinite-step" dimming and is completely feasible, though relatively expensive for patient rooms, foyers, corridors and other room systems. Two-level ("step") lighting is equally useful; once the ratio of "all on" to "dim" is established (we suggest a drop to about 40 per cent), the reduction is achieved by a fixed resistor. In fluorescent dimming, special ballasts (for dimming circuits) are necessary. The only additional wiring requirement for the usual branch-circuit is a third wire connected to each (single-lamp) ballast. Dimming ballasts have

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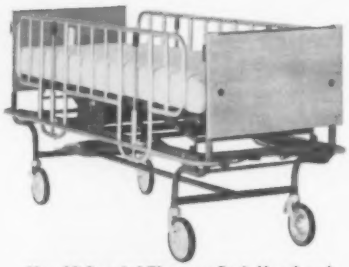
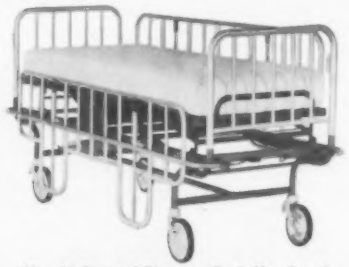


No. 42 Special Therapy Bed: Head and footboard panels are made of wood with stainless steel protective strips. Both ends removable.



No. 43 Special Therapy Bed: Head and foot ends are made of heavy gauge but light weight aluminum. Both ends removable.

● In the treatment of severe accidental injury cases the Hill-Rom No. 42—No. 43 Bed may be converted to an emergency treatment table. Transfer of the patient to the X-Ray department or operating room may be effected easily, quickly, safely.

This bed may also be used as an operating table for eye patients—the patient remaining in the bed for post-operative care and treatment.

The Labor Bed may be used as an examining table and can quickly be converted for use in an emergency delivery. The foot end can be removed and standard knee crutches inserted in the foot-end sockets when the bed is to be used for this purpose.

Each of these beds comes equipped with an IV rod, which is stored under the head section of the spring. There are six different locations for the use of the IV rod.

Procedure Manual No. 2, by Alice L. Price, R.N., M.A., author of "The Art, Science and Spirit of Nursing," explains in detail the many different uses of the Hill-Rom Special Therapy—Labor-Recovery Bed, how to use and care for the bed, etc. Copies for student nurses and graduate nurse staff will be sent on request.

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● The above illustration—from an actual photograph—shows a test you can make in your own hospital. Hold a flame from a cigarette lighter or lighted match directly against a Hill-Rom Flame-proof Curtain. The cloth will not support a flame. It will only char.

Hill-Rom Cordette, the material used in these curtains, is made flame-proof with a proven chemical process in which the chemicals actually become a part of the yarn. They also tend to increase the tensile strength and abrasive resistance of the fabric. The curtains will withstand repeated launderings without loss of the flame-proof qualities. Neither the color nor the "feel" of the fabric is affected. Actually, it will be softer after the initial laundering.

Hill-Rom Safety Curtains are available in cream, peach and green shades. Complete information and samples of the flame-proofed material will be sent on request.

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an extra lead, which is attached to a variable dimmer or to a fixed resistor, in the case of two-level or three-level lighting. For large installations, such as in a chapel, theater or auditorium, dimming may be done by the usual grid-controlled tube-reactor control. Variable dimming of either fluorescent or filament systems is done by a rheostat, a variable voltage transformer, or the tube control.

Corridor lighting has not been a feature of lighting literature. Until recently, it has been considered a sort of necessary evil. At Nela Park in the application engineering building is the first corridor lighting application "laboratory" in the United States (perhaps the first in the world). Here more than a dozen systems of corridor lighting are installed. They can be switched individually or together in various combinations. They can be studied for brightness patterns and cost analyses. They vary considerably in style and content. All are fluorescent systems. In the entrance halls, three significant applications show combinations of wall (and bulletin) lighting. One section shows an architecturally significant ceiling element, covering nearly the whole ceiling. Adjacent corridors illustrate "built-in" and "built-on" types of currently available luminaire sections.

SPATIAL APPROACH IS BEST

The effect of spaced and continuous rows is quickly demonstrable. In the first three months of its use, it was easy to see that designers found this three-dimensional approach highly valuable. As with nearly every lighting problem, the best is the spatial approach—studying the lighting within a space which is reasonably close in dimensions to the one to be built. As one designer expresses it, "Buying lighting is like buying an overcoat. You learn best what you want by having it all around you." Another visiting authority stated that he never approves a luminaire until he has examined it *lighted* with the final size and color of lamp to be used and a simulated background with ceiling, wall and floor reflectances which are reasonably close to the final choice. In this corridor lighting laboratory, many of these parameters can be supplied. Few (if any) hospital lighting designers have made use of this laboratory since its opening to the technical trade early last year. It is hoped that this mention will attract a great many more of them.

Cast Cutter Cuts Too Deep

PAUL H. KEISER

MOST hospital administrators today are aware that safety is one of their greatest concerns, not only for employes but for patients too. Many of us have taken what we believe are the necessary precautions to eliminate or minimize accidents. We have devised elaborate safety programs, conferences and even detailed reporting forms. Regardless of all precautions, hardly a week goes by when some patient does not fall out of bed, or receive some type of injury.

Our hospital is no different from others in this respect. We feel we have given careful consideration to the problem of accidents among patients and employes. Imagine our surprise, then, when we received a telephone call recently from a local attorney, stating that he had in his office a patient who had recently been dismissed from our hospital. The patient had been injured when one of our orderlies removed a cast from his leg and foot. The attorney suggested that we see the patient and discuss the injury with him. The telephone call was the first indication that the administrative office had had about the accident.

Before the patient arrived at my office I made a hurried check to see that he had actually been hospitalized here. I further checked to see that a cast had been applied and removed in the hospital. When the patient arrived I discussed the occurrence with him in detail. The patient stated that he had had a fractured right leg with some splintering around the area of the ankle. He said a cast had been applied at this hospital and that he was hospitalized for several days. Approximately five to six weeks after being dismissed he returned to the hospital to have the cast removed at the request of his doctor.

The cast was removed in the cast room by means of an electric cast cutter, bandage scissors, cast spreader, and a chisel. In the process the patient was cut on both sides of the leg from the top of the cast to the bottom. When the cast was removed it was discovered that the leg had not been covered by stockinet and sheet wadding as is the usual procedure. Stockinet had been applied over the leg at the top of the cast and over the foot at the bottom, but not throughout the body of the cast. Consequently, when the orderly removed the cast the electric cast cutter lacerated the leg and ankle on both sides. Naturally the orderly was concerned, so he and the nurse in attendance administered first-aid treatment and suggested that the patient immediately get in touch with his physician.

One of the unfortunate things about this accident was that the orderly and nurse in attendance did not report this accident according to the accepted accident report procedure in this hospital. Just whose responsibility the accident was cannot be determined. However, after this accident a policy was established in our hospital that absolutely no hospital employe should remove a cast that was not properly padded with sheet wadding and stockinet at the time it was applied. We do not wish to be critical of the doctor in this case, for it is our understanding that in some cases it is desirable to apply a direct skin cast.

As of the present date the final judgment in this case has not been arrived at. The patient's leg probably will recover with minimum scarring. Such an accident concerns us not just for financial reasons, but for reasons of public relations. We had never before been concerned with this aspect of cast removal, possibly because we believed that all casts were adequately padded and could safely be removed by an experienced orderly. We know better now. We hope that a report of this incident will help prevent similar occurrences in other hospitals.

Mr. Keiser is administrator of Burlington Hospital, Burlington, Iowa.

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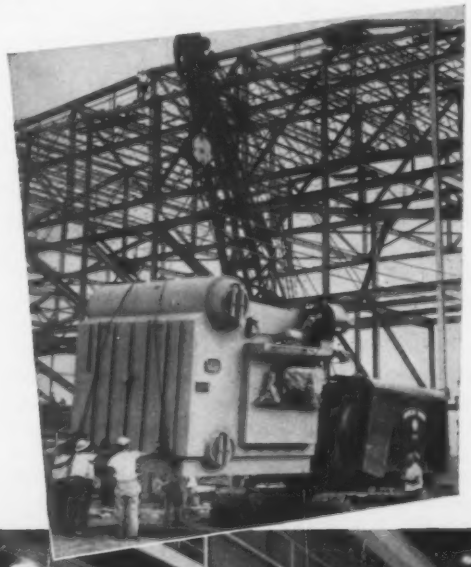

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Education Will Lend Housekeeping a Hand

Executive housekeepers seeking formal training will find encouragement in the constructive ideas given by a leading educator in home economics

LOUISE A. STEDMAN

TO SAY we are living today in a complex world is trite—but true. To say we are living in a highly competitive world is also trite—but true. To try to carry on our job, as we have been doing, bemoaning present-day conditions, won't take care of today's problems.

COMPETITION POSES PROBLEMS

Those of us who are in positions where we are helping to train young people in professions whose services are in great demand are aware of the problems arising out of the situation where many employers are competing for the too few available candidates. Some of us are also in the position of trying to compete with many others for the services of these "too few available" candidates. Someone has said, "It's the one who gets there fustest with the mostest." The law of supply and demand may result in people being hired for positions for which they are not fully qualified. Some are being advanced too rapidly in expanding businesses, or because of frequent personnel turnover. It does mean that sometimes, in the situation of too few people for too many jobs, some people may get exaggerated ideas of their value.

When jobs are so available, it sometimes means individuals may not be challenged so much to do their best and some may have the attitude, "If this job isn't just to my liking, I can leave it for something I'd like better." It means those of us who employ these people have to make salaries and working conditions more attractive. We sometimes have a little more control over the latter than the former. We can see that working relationships are pleasant, give commendation for work well done, provide opportunities for assuming more responsibility, encourage initiative, and so forth, but it is sometimes more difficult to find money to raise a salary to meet or surpass that of a competitor. And we like to think salary is not the only consideration, although it speaks pretty loudly, especially with girls who are thinking more in terms of only a few years' employment, but that other aspects of the job have appeal too. Those of us who are educating these young people have a responsibility for developing a sense of professional ethics. There is a temptation to these young people to move frequently when such excellent offers continue to come to them.

An administrator said recently, "Any good person in my organization gets at least one offer a month. And with their bags continually packed, how can you have a stable organization?"

What does this have to do with executive housekeepers and how can education lend a hand?

It is my understanding that housekeepers are interested in attracting increasing numbers of capable young women into their field of employment, and that they would like college trained women. Also, that young women with home economics training are particularly desirable. I am sure the members of the housekeeping field realize that they are facing keen competition. More home economics teachers are needed; many hospitals are without dietitians; more business organizations are requesting the services of home economists; we don't begin to supply enough extension workers, 4-H leaders, and home agents.

I could continue to cite a shortage in almost any professional field for which home economists are trained. In many areas of the country, the number of single women of college age is now at a low ebb. This is because of the low birth rate of the depression and also because young women are marrying earlier. However, there are many single young women not now in college who have college ability. They need to be encouraged to continue their education. We need to find more effective ways of persuading them of its value. The value should be expressed not only in terms of vocational opportunities but in social and cultural advantages, too.

ENCOURAGE EDUCATION FOR JOB

I believe that every group interested in employing individuals requiring specialized training or advanced education needs to feel some responsibility and take a more aggressive part toward encouraging young people to get an education to prepare for work in their fields.

How can executive housekeepers compete for the interest of students?

Have any action programs of a major nature been planned?

There is perhaps no better example of a planned campaign than that of the nursing profession. Books are writ-

Dr. Stedman is director of the school of home economics at the University of Minnesota. This article is condensed from a paper presented at the housekeeping section of the Upper Midwest Hospital Conference in Minneapolis, 1956.

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ten for teen-agers with the principal character a nurse; there are TV and radio programs on nursing as a profession. Many scholarships are given. Many organizations do not have the membership or the financial support that the nursing profession has. I am sure this would be true of the housekeeping group, since it is a relatively small one. However, the following steps could be taken:

Get information concerning executive housekeeping to high school counselors, students and parents, and see that they know about the vocational opportunities for executive housekeepers.

Find opportunities for members of the organization to contact young people in groups, as at career days; make use of opportunities to talk to individuals, for example, children of friends and acquaintances.

Arrange for tours to take interested students through institutions to see what housekeepers do.

Provide part-time and summer jobs to give students some direct contact with the work. Make these more than routine jobs.

In general, this is a long-range program and takes time to put into action on a broad scale. I realize that some needs are immediate, and parts of this can be done at any time.

Education isn't a matter only of going to college, and a college education doesn't provide all the answers. Research is making information out of date in a hurry these days. More in-service education is necessary, no matter how much previous education an individual may have had. With a shortage of qualified workers and the reduction in working hours, better management practices are necessary so that more can be accomplished in less time by fewer people. Much interest is being expressed and studies are being made to improve management practices.

Where can we start now? I cannot encourage executive housekeepers at present to think that there will be many college graduates available. What sources are there for potential executive housekeepers? Consideration may need to be given to some of the following:

1. Girls with general home economics backgrounds, who are willing to learn on the job.
2. Women who may have families of an age not requiring their full time at home.
3. Other girls or young women who are interested and willing to learn.

What can education contribute?

A representative committee from executive housekeepers' organizations might work with representatives at the college level toward the establishment of a possible college program. It would also have to be certain that there would be sufficient interest to ensure an enrollment large enough to warrant setting up a special curriculum. To begin with, rather than setting up new courses in a new major, it might be advisable to select some courses presently taught that would seem essential in meeting requirements for the executive housekeeper and add

The Institute Program Is on Its Way

MADGE H. SIDNEY

SOME 55 executive housekeepers from hospitals and hotels in Washington, Oregon and British Columbia attended a hospital-hotel housekeeping institute December 7 and 8 at the University of Washington, sponsored by the school of home economics and the Puget Sound chapter of the National Executive Housekeepers Association. On the first day, a program on work simplification and body mechanics was presented, with lectures, films, demonstrations and group discussion. The following day was devoted to human relations and personnel problems presented with lectures, group discussion and rôle playing.

The success of this institute has inspired the sponsors to plan a series of housekeeping institutes for 1957.

Since last June, when the National Executive Housekeepers Association adopted a resolution presented by the Puget Sound chapter and formed an Educational Policies Commission, housekeepers have united their efforts to plan institutes and extension courses in housekeeping throughout the country and to date courses have been established at Arizona State College, Tempe, Ariz. (evening extension course—17 weeks); Boston University, Boston (evening extension course—15 weeks), Los Angeles City College, evening extension course, starting February 7.

The tentative planned curriculum for executive housekeeping in the school of home economics at the University of Washington will be presented to the curriculum committee in the near future. Letters showing the need for such a program and approval of both the curriculum and the planned internship program have been received from the American Hotel Association, the Washington State Hospital Association, and from administrators of several hospitals in the Seattle area.

The Doctors Hospital, Seattle, has agreed to provide an internship and Firland Sanatorium has expressed willingness to offer a three-month affiliation in isolation technic and laundry management.

Housekeepers are working together toward a common goal—higher education for the future housekeepers. The year 1956 brought many changes—1957 should show many more. With such fine cooperation among hospital and hotel housekeepers, between the national board and local chapters of the N.E.H.A., and with administration and management supporting their plans, attainment of the goal is inevitable.

Helen Anderson of the University of Washington School of Nursing demonstrates to a housekeeper how proper table height and distance to the floor help her relax while she is working.

Mrs. Sidney is executive housekeeper, Doctors Hospital, Seattle.

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"Little things affect peoples' attitude toward you"

them to the base of the general home economics major. In the immediate future one cannot expect to get many college trained girls and particularly those with training in the field of executive housekeeping. In the meantime, much can be accomplished through an inservice training program.

Representatives from the field of education could work with the housekeepers' group in setting up inservice training classes. I would assume that most of the executive housekeepers and their assistants would find it difficult to be away from the job for any length of time on a full-time basis, because their services are needed where they are presently employed. Financially, it might not be possible for some to take time off. This inservice training might take the form of a series of meetings once a week for a period of time, or an intensive two or three (or more) days' workshop type of class.

I am sure no one will know better than a committee of executive housekeepers the needs, the kind of help wanted, and the type of meeting, whether it is an organized class with a series of meetings, intensive workshop, or whatever. Some places to which housekeepers might turn for sponsoring of such classes are:

1. Extension divisions of the various universities.

2. The adult evening program of the public schools.

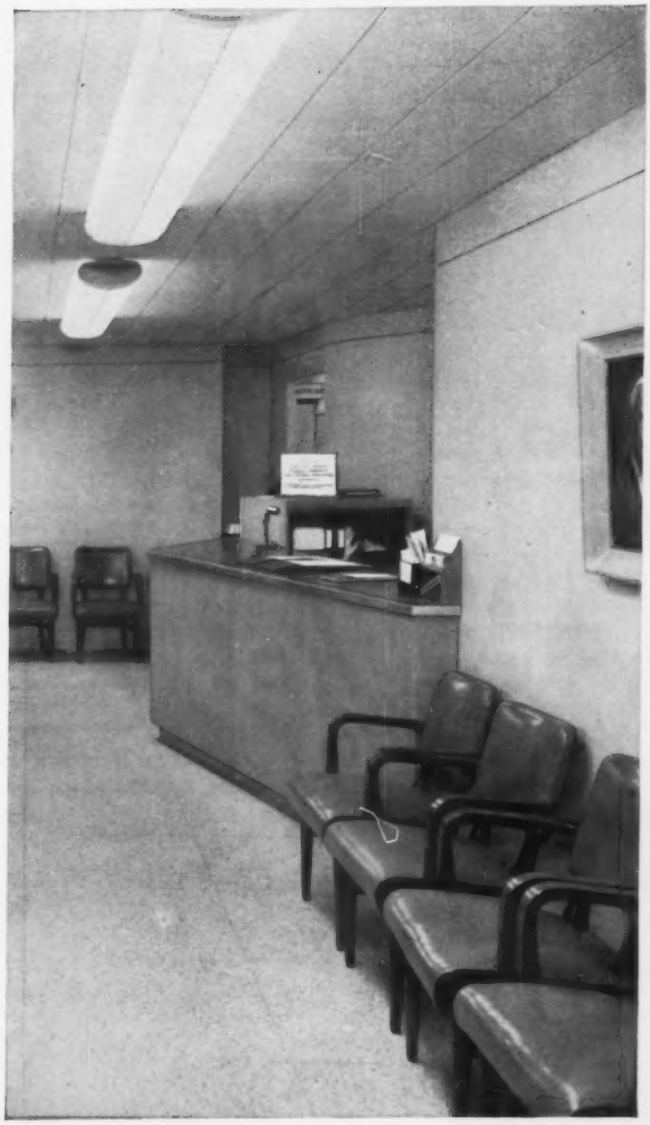
It might even be desirable for the housekeepers' groups to organize their own classes and obtain their own paid instructors. In any instance, a group should be large enough to warrant the organization of a special class.

There may be a series of meetings on such subjects as management practices, new developments in textile commodities, new housekeeping tools and supplies, or personnel management.

Many institutions that use the services of people with varying specialized training find the concept of teamwork very valuable. In many instances it has been proved that mathematics add up differently here. In other words, four different individuals when working together on a team accomplish more than these same individuals working separately. One, plus one, plus one, plus one may equal four working independently, but one, plus one, plus one, plus one may equal more than four when talents are pooled. The old adage may work here too, "A chain is as strong as its weakest link." Each member in the team will generally be a better member if he feels adequate to cope with his responsibilities and as well prepared for his job as are other members of the team. The executive housekeeper will be working on a team, whether it is in a hospital, a hotel or a club, with some other team members who are highly trained. She will feel more secure, I believe, if she is well trained for her job and knows modern practices in her field, whether her knowledge has been gained through a formal college education or organized inservice courses. If she feels well qualified for her job, that feeling of confidence will carry over to those with whom she is working.

Since the housekeepers have a felt need, a keen interest in finding answers to the problems that arise, professional pride, plus the enthusiasm to recruit others, I am sure those of us in the field of education will be happy to lend a hand and work with them. This we will do in whatever way would seem desirable, to help to continue in the best way possible the very necessary services of the executive housekeeper.

Texas hospital proves it!



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YOU CAN DEPEND ON DOW

New Psychiatric Unit Offers Integrated Care

(*Continued From Page 59*)

conferences. They are located on every floor except the basement.

One of the unusual features of this second floor office area is a waiting room opposite the elevators. Although it is actually one large waiting area, it is divided by 6 foot partitions into three separate units. Thus patients do not have to sit staring at one another. It will also allow different types of individuals to be separated, *i.e.* psychiatrists' private patients, staff patients, people seeing social service workers, and so on.

The children's inpatient unit is a locked ward. The nursing station, which is another locked unit as it is on the fourth floor, is located half in the closed section and half in the open area. This permits personnel to enter and leave the station without having to go through locked doors. It also permits the nurses to view visitors. Entry is by means of an electrical lock release operated in the nurses' station.

The floors of this unit and fifth floor are radiant heated, thus affording comfort and protection to patients. Because the radiant heating device is slow to react to changes in outside temperature, only 40 per cent of the room heat is provided by this means while 60 per cent is circulated by means of warm air from grilles in the ceiling.

This division, like the other units, has a nurses' lounge, a treatment room, a utility room, a kitchen, and a dining room. The dining room has a fine decorative touch in three 4 by 6 foot color photographs of scenes from live animal motion pictures produced by Walt Disney. The dining service on this floor will be family style. A Dutch door connects the kitchen and dining room. Tables are arranged to seat four to six children. One table is lower than standard height for smaller children.

The corridors of this unit are extremely wide (12 feet 5 inches) to provide a play area for the children. The walls are cement enamel for durability. Metal pan acoustical ceilings help tone down the noise. Vinyl tile flooring has been used throughout.

Off one end of the corridor is a playroom which has been furnished with benches, low tables, television, a piano, and various games and toys. Outside the playroom is an open play deck which is actually the roof of one wing of the building. Access to the play deck is through a door in the playroom and a ramp has been provided so that toys can be ridden or driven onto the deck. The area is completely enclosed in protective wire mesh. Part of it is roofed over for use in inclement weather and as a summer sunshade. A shower has been provided for summer splashing.

Windows on this floor, as on the other locked units, are protected by flush-mounted detention screens in the rooms; there is no window sill on the room side of the screen to offer the possibility of climbing.

All rooms on this floor are two-bed except for two isolation units. A double wardrobe closet and a chest of drawers are built into each room. The furnishings, as they are everywhere possible in the building, are like those at home rather than at a hospital. The bed capacity of this unit is 19.

An isolation unit of three rooms can be completely shut off from the rest of the section. Two of three rooms are designed for bedrooms. The third room is a small playroom. The isolation suite also contains a tub room and a bathroom.

LINEN STORED IN CARTS

Linen storage on this and other floors is by means of carts. The clean linen is placed in separate sections of the cart kept in a specially designed spot in each utility room. When fresh linen is needed it is removed directly from this cart rather than from storage. Dirty linen is removed by means of a linen chute opening on each floor corridor but concealed behind locked doors.

The third floor is an open floor, *i.e.* there are no locked doors or detection screens. Here patients who are nearly ready to go home and those with psychosomatic disorders are housed. The unit is L-shaped with the nurses' station at the intersection of the corridors. The rooms here are about 50 per cent double and 50 per cent single.

This floor, as well as the fourth and fifth, has floor waiting rooms, a doctor's office, and conference room in addition to the facilities already described on the second floor. One further feature of the third, fourth and fifth floors is a laundry room on each floor for patients' use. Each room is equipped with an automatic washer and drier, laundry tubs, and a built-in ironing board.

The third and fourth floors both have a dayroom and sunroom apiece. These are at opposite ends of each floor and are each furnished in an entirely different manner. The dayrooms have built-in library shelves, television cabinet and storage closets for games and card tables. Each dayroom has a piano. The dayrooms, sunrooms, floor waiting rooms, and dining rooms all have wallpaper as well as paint.

Both floors have rubber tile flooring, acoustical ceilings in the corridors, and painted plaster walls. A few of the rooms on the third floor are equipped with fly doors, cubicle curtains, and hospital furniture for those patients who require bed care. Otherwise, the rooms are furnished as they would be in a home except that the furniture is metal.

Numerous psychiatric hospitals are designed with the room doors swinging into the corridor. While this prevents the patient's barricading his door from the room side, the doors standing in the corridor prevent adequate view down the length of the corridor, interrupt traffic flow, and are a hazard. On the fourth floor, a device has been built into the door frame which permits the door to swing into the room for normal use; however, should the patient barricade the door, the insertion of a simple hexagonal key in the device permits the door to be swung into the corridor so that the room can be entered.

All locked exit and firetower doors can be released electrically from the nurses' station.

Throughout the entire building, great care has been given to the selection of hardware and the keying of locks. Hardware selection varies according to the class of patient treated; thus, locked wards have varying degrees of safety features incorporated in the hardware. In general, however, all locked wards have recessed grips instead of doorknobs, door closers are replaced by floor roller checks, all hinges are rounded off and have no projecting pins.

Keying has been simplified to circumvent the annoying problem common in many institutions of requiring the personnel to carry a different key for each lock. In this building the philosophy is that locking is not so much against an intruder as against a person on the inside who possesses no key;

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consequently, most locks are keyed alike.

The fourth floor also contains an isolation room for patients needing physical care or those who must be separated temporarily from the rest of the floor.

The fifth floor contains an occupational therapy unit featuring facilities for ceramics, woodworking, weaving and art work. This unit is to be used only by psychiatric patients in this building.

Most of the electro-convulsive therapy is administered in the treatment room on this floor. Therefore, it has a small recovery room adjoining.

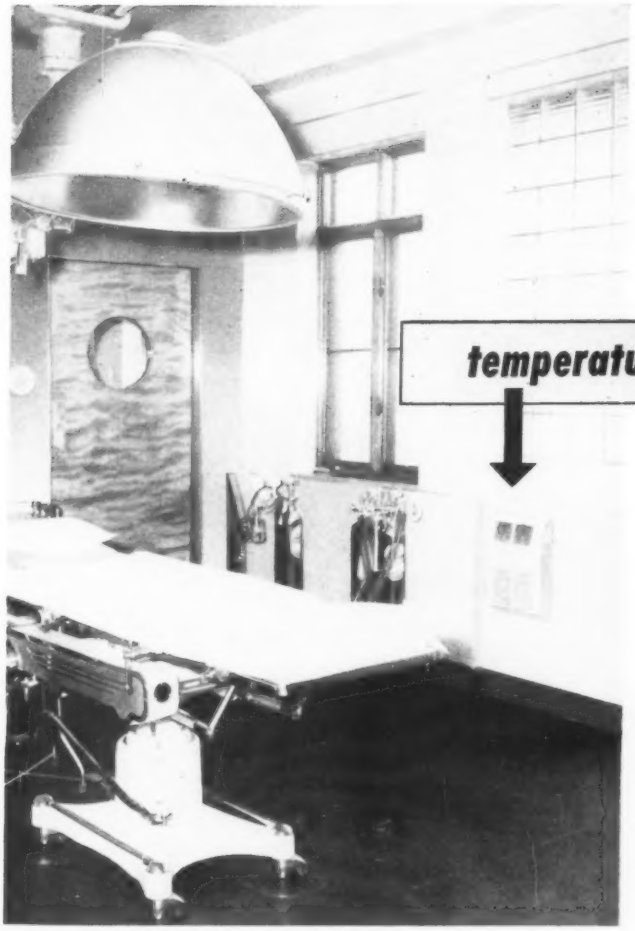
This floor is divided into four parts: (1) male patients, (2) female patients, (3) working area, and (4) an open area. This is the only floor on which men and women are segregated, because it is the area of treatment for acutely ill patients.

The nursing station is placed at a 45 degree angle to the flow of the rest of the floor, thus providing views in all directions. The view windows are placed at such height as to permit a seated nurse to look out, but low enough to discourage patients from staring continuously into the nurses' station. The women and men have separate dayrooms which are used as dining areas as well for those who can eat outside their rooms.

The patient rooms are five-sided to provide a view of the patient through the viewing aperture in the door no matter in which part of the room the patient may be. The rooms have terrazzo floors, cement enamel walls, and metal pan acoustical ceilings. Floor drains are provided in the corridors outside the rooms. Locker rooms are located in each section for storage of patients' clothing. One room is isolated from the other sections for those patients who need to be especially protected or who are physically ill. It also permits greater flexibility in that it can be used for either male or female patients, the room being physically separated from both units.

The fifth floor has two sets of locked doors between the patients and outside areas.

The working corridor of the fifth floor, on which are located the nurses' station, utility room, treatment area, nurses' lounge, and janitor's closet, is completely segregated from patient areas so that the routine nursing and housekeeping tasks can be accomplished without contact with patients.



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Massillon City Hospital, Massillon, Ohio. SelecTemp heating unit is shown in one of the Massillon City Hospital operating rooms, above. SelecTemp advantages pointed out by hospital officials are: (1) automatic temperature control in each individual room permits heating of each room to fit the needs of the patients. (2) units have non-electric fans and thermostats, a special advantage in rooms where sparks are dangerous.

Circulated, filtered warm air, heated by steam. SelecTemp is a revolutionary application of steam heat. The small, compact heating units are recessed in the wall, requiring no floor space. Each unit contains a thermostat, air filter, heat exchanger, and air circulating fan. The same steam that heats the air drives the circulating fan. The high capacity and efficiency of room heating units, due to forced circulation of air through heat exchangers, make the space-saving, small SelecTemp room units possible. The 18,000 Btu unit (above) for example, weighs only 22 pounds, is set in a wall opening 17" x 15½", and can deliver as much heat as 75 feet of standing steam radiation.

A thermostat in every room. Temperature can be regulated *to fit the patient's needs.* The selected temperature is uniform throughout the room, with a gentle, steady circulation of clean, filtered air. Individual optimum temperatures can be maintained in such rooms as surgeries, recovery rooms, nurseries, laboratories and kitchens.

Safe in operating rooms and laboratories. Each steam operated room unit contains a filter, an air circulating fan and an individual thermostat. Both fan and thermostat are *non-electric.* Since no electricity is used, SelecTemp units are spark-free and safe in rooms where inflammable gases are present.

No unbalanced heat. Rooms are equally comfortable on the cold or sunny side of the building. Each room gets the heat it needs—no more, no less.

SelecTemp is a modulating system. This is the secret of SelecTemp's wonderful steadiness and comfort. Heat flows into the room at whatever rate is required to replace heat loss. SelecTemp is not a "pop-on, pop-off" system. Each SelecTemp unit operates in a range varying from "idling speed" to full capacity—always under thermostatic control.

Low cost. SelecTemp can be economically installed in old or new buildings, at a cost comparable to that of many systems *not* having individual zone control. Overheating is eliminated, resulting in substantial fuel savings.

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NEWS DIGEST

Surgery Performed on 39.4% of Patients . . . Dr. McGuinness Succeeds Dr. Coggeshall as H.E.W. Assistant . . . Dr. Bluestone Honored at Testimonial Dinner . . . Health Organization May Eliminate Insurance Gaps . . . P.H.S. Finances Pharmacy Survey

Surgery Performed on 39.4% of Patients in Hospitals, A.M.A. Survey Indicates

CHICAGO. — About 8,100,000 persons hospitalized in the year 1954, or 39.4 per cent of the total number of patients, underwent surgery, according to a survey published in December in the *Journal of the American Medical Association.*

Among these surgical procedures were about 1,100,000 tonsillectomies and about 500,000 appendectomies. Hospitalized patients who had these two operations amounted to 5.4 per cent and 2.4 per cent, respectively, of the total number of inpatients discharged during the year.

Of those discharged from nongovernmental general and special hospitals, the ratios were 6.3 per cent for tonsillectomies and 2.6 per cent for appendectomies.

The study is the second of a series of surveys which is expected to be completed in several years. The first presented data on age and sex distribution of patients treated by physicians in hospitals.

Future studies will deal with estimates of the numbers of patients seen by physicians in the home and in the office, and with the numbers of patients in all diagnostic groups seen during a selected week in all hospitals. Another study will concern the amount of time spent by physicians in treating accident victims.

Of the discharged inpatients treated during 1954, a total of 18.4 per cent were classified as obstetric. These numbered approximately 3,800,000—about 500,000 more than the number of births in hospitals reported by the American Hospital Association for the 12 month period ending Sept. 30, 1954.

In addition to the obstetric and surgical inpatients discharged, there were about 8,800,000 classified as "all others." These included persons treated in hospitals for a great variety of conditions and some well persons who were hospitalized briefly by their doctors for "physical checkups."

An estimated 4.9 per cent, or about one million, of patients in all types of general and special hospitals (from which 98.3 per cent of all inpatients were discharged) had primary diagnoses of some form of cardiac disease.

About 585,000 had primary diagnoses of some form of malignant neoplastic disease. This was 3 per cent of the number discharged.

About 720,000, or 3.6 per cent, were diagnosed as fracture cases, it was reported.

These three diagnostic categories—cardiac, cancer and fractures—accounted for a total of 11.5 per cent of all inpatients discharged from Veterans Administration hospitals. Malignant neoplastic disease accounted for 6.5 per cent of those discharged from state hospitals, and fractures comprised 4.2 per cent of discharges from local governmental hospitals.

The authors, Frank G. Dickinson and James Raymond, noted that one interesting result of the survey was that at least 22 per cent of patients treated by physicians in hospitals during 1954 did not have diseases but were hospitalized for conditions related to pregnancy (18.4 per cent) or accidents (3.6 per cent).

The series of studies is being carried out under the auspices of the A.M.A.'s Bureau of Medical Economic Research, of which Dr. Dickinson is director.

"When this series is completed several years hence," according to the authors, "the bureau will have presented a rough estimate of the totality of the services rendered annually by physicians to the American people. It will then be possible for the first time to present a counterpart to the total expenditures of the people for medical care—the value side as well as the cost side of physicians' services.

"In other words, this series of studies is designed to describe what we get in terms of ailments treated for what we spend for physicians' service."

New Officers Installed

New officers of the Illinois chapter, American Association of Hospital Accountants, installed at the president's Christmas luncheon in Chicago: (left to right) Robert J. McMahon, hospital accounts analyst, state department of health, president; Sister M. Rita, St. Francis Hospital, Evanston, secretary, and Duncan Bryant, Perry Memorial Hospital, Princeton, vice president.

Ban Discrimination in Private Nursing Homes

NEW YORK. — Under a new regulation, private nursing homes here that care for welfare recipients will be required to give proof that they do not practice discrimination if they wish to be on the list of the city department of welfare.

The rule requires that each of the 88 private nursing homes submit a resolution declaring that it "accepts as patients persons of all races and faiths and that no one will be rejected solely because of his race, color, creed or national origin." Every nursing home on the department's list is required to be operating on a basis of complete integration by June 1 at the latest.

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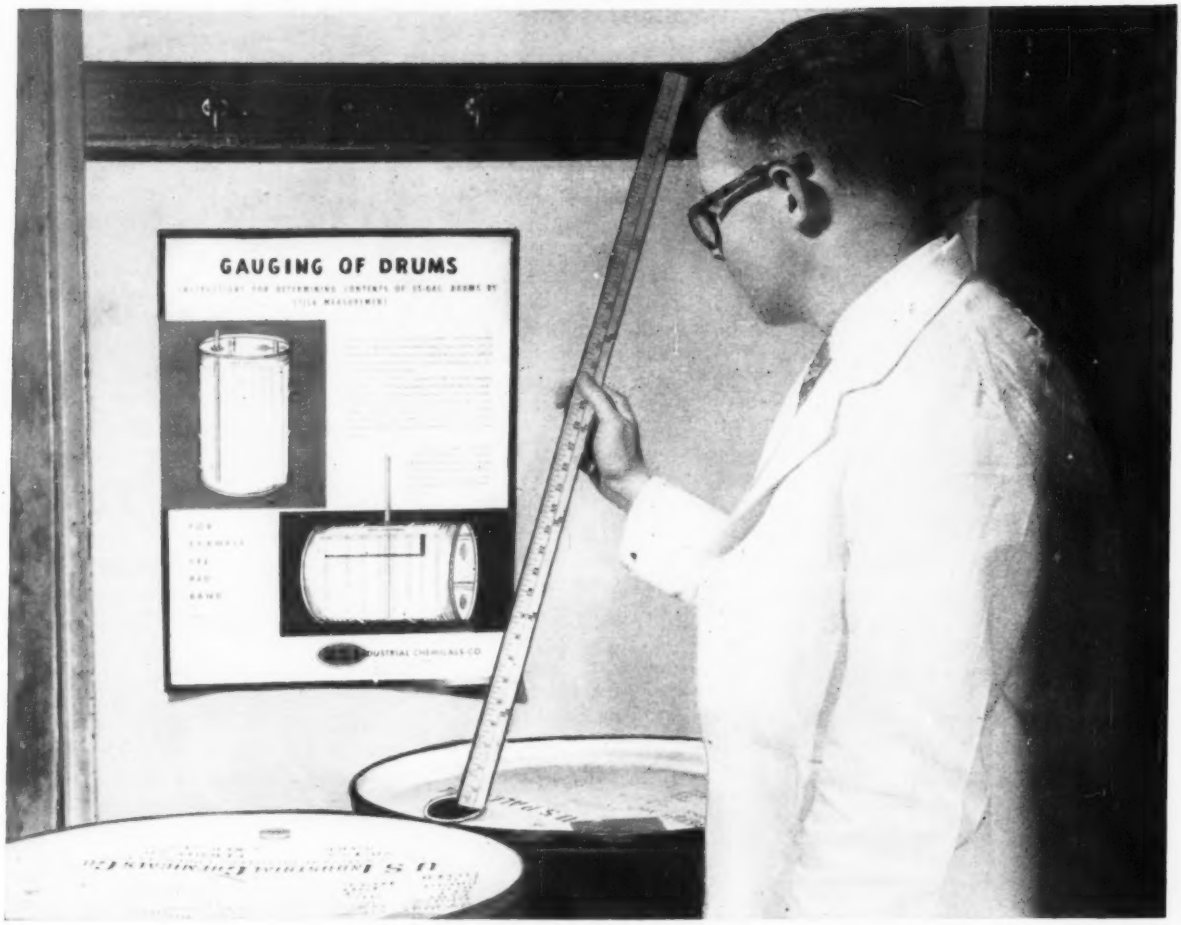

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For your free copy of the alcohol drum gauging chart shown above, write to your nearest U.S.I. sales office or to Department H at the address below. Please indicate whether you prefer the letter size, wall-chart size, or both.

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Dr. Aims C. McGuinness Is Successor to Dr. Coggeshall as H.E.W. Special Assistant

WASHINGTON, D.C. — Dr. Aims Chamberlain McGuinness was sworn in last month as special assistant for health and medical affairs to the Secretary of Health, Education and Welfare. Dr. McGuinness succeeds Dr. Lowell T. Coggeshall, who resigned to return to his position as dean of the division of biological sciences at the University of Chicago. The appointment is subject to confirmation by the Senate.

H.E.W. Secretary Marion Folsom (left) administers the oath of office to Dr. Aims C. McGuinness as his special assistant for health and medical affairs.

Dr. McGuinness has been a member of the faculty of the school of medicine at the University of Pennsylvania since 1934, and associate professor of pediatrics since 1951. He received his bachelor's degree from Princeton University and his medical degree from Columbia University. Following internship at the University of Pennsylvania Hospital and Children's Hospital, Philadelphia, Dr. McGuinness began private practice in pediatrics in Philadelphia.

Dr. McGuinness was director of Children's Hospital in Philadelphia from 1948 to 1951 and dean at the University of Pennsylvania graduate school of medicine from 1951 to 1954.

In 1954 he served as clinical director of the Miners Memorial Hospital Association of the United Mine Workers Welfare and Retirement Fund.

"While the department has an interest in all matters affecting the health of the American people, certain areas of health are engaging our special attention at this time," H. E. W. Secretary Marion B. Folsom said. "We are encouraging communities to develop hospital facilities more responsive to the needs of those who are not acutely ill, with emphasis on self-service.

"We are also encouraging communities to build more chronic disease facilities and nursing homes, to serve primarily our increasing population of older people. We are seeking the expansion of health insurance on a voluntary basis, to help meet the rising cost of medical care. And we are especially concerned with the problems of costs of medical care for low income groups, particularly elderly people.

"Dr. McGuinness' knowledge and abilities will provide invaluable assistance in meeting these and other problems, and in the department's total effort to help improve the individual and environmental health of the American people."

Hospital Pharmacy Survey Financed by P.H.S. Grant

ANN ARBOR, MICH. — A study designed to determine how pharmacy service is being provided to patients in the nation's hospitals is under way, made possible by a grant from the U.S. Public Health Service.

The first comprehensive, national study of pharmaceutical service in hospitals undertaken in this country, the survey is being carried out by the division of hospital pharmacy of the American Pharmaceutical Association and the American Society of Hospital Pharmacists.

Investigators carrying on the survey will perform five functions: (1) examine present methods of pharmaceutical practice and service in hospitals; (2) outline the elements of pharmaceutical service that will promote better patient care; (3) determine how these elements of service may be more effectively performed for the benefit of the patient, the medical and allied staffs, and the hospital; (4) consider the education and training desirable for hospital pharmacists to enable them to perform these elements of service, and (5) recommend a plan of action for the implementation of the findings of the survey.

Dr. Don E. Francke, chief pharmacist at University Hospital here, is director of the survey, in cooperation with the survey research center at the University of Michigan.

Michigan State Offers Food Service Training

EAST LANSING, MICH. — For the second year, Michigan State University is offering a 10 week course of intensive training for food service supervisors. The 1957 class is scheduled to begin March 4 and will be open to persons from hospitals in states other than Michigan.

Total registration will be limited to 40 persons. Any person recommended by an administrator of a hospital or institution and who can benefit from the program of instruction may apply for the course. Margaret Gillam of the college of home economics at Michigan State is course coordinator.

Dr. Bluestone Honored at Testimonial Dinner

NEW YORK. — Dr. E. M. Bluestone was honored at a testimonial dinner here in December by more than 300 leaders in the hospital and public health fields on the occasion of his 65th birthday and completion of 35 years of service in the hospital field.

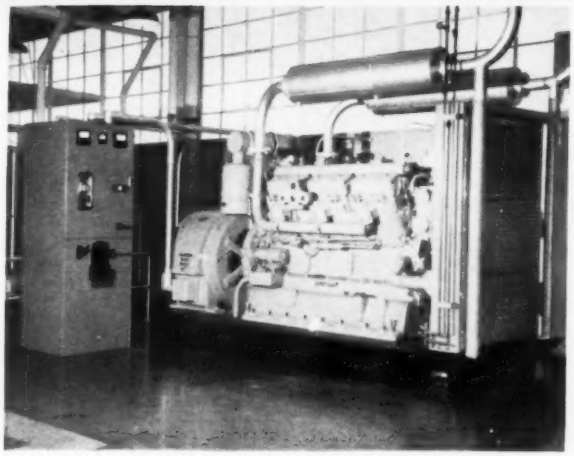
Dr. Bela V. Schick, pediatrician; Dr. Basil C. MacLean, new president of the Blue Cross Association, and Dr. Jack Masur, assistant surgeon general of the United States, were among those present at the dinner. Dr. Masur was dinner chairman and also the main speaker.

Dr. E. M. Bluestone (left) receives a life-sized portrait of himself from Dr. Abraham Jezer, president, Alumni Association of Montefiore Hospital.

A founder and former president of the American Association of Hospital Consultants, Dr. Bluestone has been associated administratively with Montefiore Hospital here for the last 28 years, for 22 years as its active director and for six years as consultant. He is a member of the editorial board of The MODERN HOSPITAL.

"NOW, in case of power failure... our entire operation goes on as usual"

K. A. Rindflesh, *Administrator*



Ventura County General Hospital, in Ventura, California, is a modern 400-bed institution in which local people can take pride.

But like many fine hospitals, this one lacked a vital factor when it first went into operation. That was complete, reliable standby power. The only emergency power available, in case of a power-line failure, was some battery-operated spotlights and a small portable generator for use with the iron lungs.

Today there is a 350-KW CAT* D397 Electric Set at Ventura County General Hospital. If a broken power pole, earthquake, flood or any other mishap interrupts service, this big diesel generator starts automatically and takes over the full load in seconds.

K. A. Rindflesh, Administrator, reports: "Now, in case of a power failure, be it a few minutes, an hour or a week, our entire operation goes on as usual. Every function of the hospital continues without interruption. The operating rooms, delivery rooms and emergency rooms are ready for use; also, the x-ray, laboratory and other equipment such as iron lungs, heating, air conditioning, kitchen, refrigerators—everything including the elevators."

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MODERN STANDBY ELECTRIC POWER

New Health Organization May Eliminate Gaps in Present Insurance Plans

DETROIT. — A new voluntary, nonprofit health organization, called the Community Health Association, is being developed here to provide comprehensive prepaid health service of high quality for persons in metropolitan Detroit.

Founders of the organization say its aim is to eliminate gaps in the protection afforded by existing health care plans. If it is developed according to present plans, they believe the association could become a major competitor of Blue Cross and Blue Shield.

The association was formally organized in October by a group of labor, religious, educational and business leaders here. Walter P. Reuther, president of the United Automobile Workers, spearheaded the move and is serving as temporary chairman of the board of directors.

"Prevailing health insurance plans," according to Mr. Reuther, "deal with a small part of medical care. They overemphasize hospitalization and surgery. At best, they cover only about one-third of the average family's medical bill."

He continued: "Many of the benefits are hedged in by cash limits that leave the patient with large bills for services he thought were covered. Gross overcharges for doctors' services are commonplace. Contrary to basic precepts of modern medicine, few plans make any provision for preventive care or encourage early diagnosis of illness."

Details of the association's plans are not complete. However, the thinking of those promoting it points toward a program somewhat like that of the Health Insurance Plan in New York.

The aim here would be to provide preventive diagnostic services, medical care at both home and office or factory, and surgery, hospitalizations and miscellaneous services such as x-rays.

Medical care would be provided by doctors practicing in groups. These groups would be attached to participating community hospitals.

P.H.S. Reports Survey of Nursing Services

WASHINGTON, D.C.—Public Health Service has released results of a survey of nursing homes and hospitals offering skilled nursing service that may be interesting but that contains few surprises. The study covered 564,826 beds in 5200 general hospitals and 171,106 beds in 6531 skilled nursing homes.

General hospital beds in built-up communities averaged 4.1 per thousand population, in contrast to 1.8 hospital beds and 0.4 nursing home beds in isolated rural areas.

Furthermore, the supply of both types of beds was found to increase with an increase in per capita income. Other correlations: more nursing home beds where there are more older people, but no increase in hospital beds in such areas; more beds of both types in places where the supply of doctors and nurses is relatively high.

Correction

On Page 168 of the November issue of The MODERN HOSPITAL it was erroneously reported that **Harry J. Kessler** is the new administrator of Cottage Grove Hospital, Cottage Grove, Ore. **Fred L. Morris** has been the administrator of Cottage Grove Hospital since 1950.

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Bed Shortage Alleviated; Physicians Follow Rules or Lose Staff Privileges

ORADELL, N.J. — In an article in the January edition of *Medical Economics*, Drs. Kenneth W. Taber and Donald E. Stader describe how they and their colleagues overcame the bed shortage in a 400 bed hospital in Allentown, Pa.

First step in tackling the problem was to determine its cause. An investigation by the medical staff turned up the information that some doctors "made reservations in two or three hospitals for the same patient.

"Some put special pressure on the hospital to make sure their patients were admitted. A few even upgraded elective procedures to emergency status to obtain priority. Some of those whose patients had health insurance appeared more than ready to hospitalize them rather than treat them at home."

Appointed as a two-man team to improve the situation, Drs. Taber and Stader set up a schedule of emergencies, dividing them into three categories: critical cases (which had to be admitted at once); serious cases (which needed hospital attention within three hours), and urgent cases (which didn't require immediate hospitalization but took priority over routine reservations).

They requested their staff colleagues to list each emergency admission under one of the three categories. And the two doctors met every morning to check the admissions list.

The investigating committee had been empowered to delay bed reservations made by doctors who violated its rules. If the recalcitrant physicians persisted, the committee also could recommend that their staff privileges be revoked.

These enforcement powers soon had all staff physicians adhering to the new criteria for admitting patients.

The two doctors also urged their colleagues to expedite consultations and to refer patients before, rather than after, hospitalization. And they levied an extra charge on patients who checked out late on their days of discharge.

"Many well insured patients insisted on getting their 'money's worth' of hospitalization," the two doctors wrote. "Since it isn't always easy for the attending physician to correct this, we of the committee openly assumed responsibility for ordering the discharge of patients who had outstayed their welcome."

According to Drs. Taber and Stader, the new regulations soon wiped out the heavy backlog of reservations, they cut the average patient's stay, and they enabled the hospital to accept a greater number of patients than ever before.

Young Adults, Teen-Agers Need Polio Vaccine Shots, Basil O'Connor Warns

NEW YORK. — The American people still are faced with more than half the job of protecting themselves against polio, according to Basil O'Connor, president of the National Foundation for Infantile Paralysis.

"The shocking fact remains that only one out of every six Americans between 20 and 35 years of age has even been started on inoculations against polio," Mr. O'Connor said last month. "And since the three-shot series takes eight months to complete, and the polio season begins with summer, we are running out of time."

Of particular concern to the March of Dimes organization is the lag of vaccinations in 1956 among teen-agers and young adults. Good progress has been made with the vaccination of infants and children of grade school age. However, Mr. O'Connor warned that unless high school and college students avail themselves quickly of protection, the heaviest percentage of future polio cases may afflict these age groups.

By mid-November, 44 million Americans had received at least one shot of the Salk vaccine. This compared with the 10 million children, mostly in the first and second grades, who were vaccinated in 1955.

In 1956 polio attacked nearly 16,000 persons, according to Mr. O'Connor. This was a 45 per cent decrease from the 1955 total and a 58 per cent decline from the 1951-55 average. It was the lowest number of cases recorded since 1947.

The supply of Salk vaccine on hand and in the making was considered adequate practically to wipe out paralytic polio if every American up to 35 years of age received all three shots. That means a three-shot series for a total of 97 million men, women and children up to age 35, of whom 53 million have not yet received their first shots.

Of the 44 million who have received shots to date, only 7 million have completed the full course of inoculations.

Group Seriously Ill for Specialized Care, Vane Hoge Suggests

NEW YORK. — The obvious solution to the problem of caring for seriously ill patients is to collect them into one place with specialized equipment and specially trained personnel, according to Dr. Vane M. Hoge, assistant surgeon general, U.S. Public Health Service, who was one of several speakers at a symposium conducted by the American Association of Hospital Consultants here in December.

The assistant surgeon general indicated that general hospitals constructed in the future probably will include such special intensive treatment areas.

Grouping the sickest patients nearest the ward nurses' station or providing private duty nurses for the critically ill in private rooms have long been standard methods of caring for them, Dr. Hoge said.

"But neither location, as a rule, has the necessary equipment for intensive care, nor do they easily lend themselves to adaptation," he indicated.

Dr. John E. Gorrell, director of medical services of the National Foundation for Infantile Paralysis, suggested that hospital planners show consideration for patients, hospital personnel, visitors and doctors by building hospitals in more accessible areas.

"The appeal of the open country to the well person has been greater than the intelligence to recognize the importance of having the patient and his hospital where he can easily be reached," Dr. Gorrell said.

Dr. Morris Hinenburg predicted that patients will resist the kind of intensive treatment setup suggested by Dr. Hoge. Dr. Hinenburg, who is medical care consultant for the Federation of Jewish Philanthropies of New York, said patients might oppose changes from one type of accommodation to another within the same institution and might refuse to accept the explanation that this is done because of changes in clinical requirements.

Radiologists Find Fault With Academy Report; Fear Poor Diagnosis

NEW YORK.—Reducing medical use of x-rays too drastically would lead to risk of poorer diagnosis and less effective treatment of disease, according to the American College of Radiology. However, recent discussion of radiation exposure has left the impression that all medical x-rays are bad.

The college termed the lack of distinction between necessary medical x-rays and other sources of radiation "seriously wrong" in a statement relating to the recently published "Biological Effects of Atomic Radiation, Summary Reports," by the National Academy of Sciences-National Research Council.

While commending the work of the N.A.S. in studying the problem, the college leveled sharp criticism at persons who "have fostered the erroneous idea that the N.A.S. reports dealt largely with the injudicious or extravagant use of diagnostic x-ray procedures by the medical and dental professions.

"As radiologists, we have the training, duty and privilege of aiding with such evaluation [of dosage] and we repeat: Keep the dose as low as you can.

"It is in this area especially that special knowledge and experience of the physician are important," the college said. Knowledge and experience make it possible for the physician to know when any dose should be given, what measurements of the dose should be made and how to so limit the radiation that the genetically important tissues are exposed to the least possible amount.

"It is in the very area of keeping the dose low that so much radiologic research is being done, in order to get more and more information with steadily reduced doses," the statement said.

The N.A.S. reports were criticized for arbitrarily calling for dosages amounting to no more than 10 roentgens of man-made radiation to the reproductive cells.

". . . When, in a careful physician's judgment, an individual patient requires a dose exceeding 10 roentgens or any other arbitrary figure, his medical judgment must prevail," the statement contended.

The radiologists also depreciated the value of "personal exposure" charts, or permanent records of medical x-ray examinations, calling this N.A.S. recommendation "premature and inadequately considered, if not totally unfeasible at this time.

"For medical exposures the keeping of personal records seems to be of highly dubious accuracy and value. No suitably reliable methods are available for direct measuring of gonadal exposure in procedures such as gastrointestinal fluoroscopy. Much more research needs to be done with respect to the validity of gonadal dose computations (not direct measurements) for other radiographic procedures . . . and it would seem unlikely that such records, even if they were well kept, would be helpful in deciding whether individual persons should or should not have medical examinations or treatment."

The statement also pointed out that the genetically significant figure of radiation is now unknown. It said, "The figures are clearly not really satisfactory to any geneticist. Too much has been assumed; too little is dependably known."

The college indicated that appropriate training and experience must be

insisted upon for all users of radiation, lamenting that "of the 126,000 professional users of x-ray apparatus today, it is reported that only about 4000 have the comprehensive special training of radiologists."

Other recommendations by the college included careful weighing against possible hazards any mass x-ray screening programs or surveys.

"In medicine, one way of keeping diagnostic dosage to a minimum," the statement concluded, "is to make every effort to have a given examination done right the *first* time."

Surgeon Dropped From Staff Sues Hospital, Asks Court for Reinstatement of Privileges

PASSAIC, N. J.—A surgeon who was dropped from the staff three years ago has sued the Passaic General Hospital here for $655,000 damages, claiming he was "practically put out of business" because he wasn't permitted to perform surgery at the hospital when his appointment to the emeritus staff was not renewed.

In a separate suit, the surgeon, Dr. Morris Joseph, also asked for reinstatement to the emeritus board of surgeons of the hospital, from which he was dropped in 1954. He had resigned as an active surgeon two years earlier, it was reported.

Hearing the case without a jury in the superior court at Hackensack, Judge Donald M. Waesche listened to a pretrial deposition read by an attorney for Dr. Joseph, in which John C. Barbour, hospital treasurer, said the hospital was investigated by the American College of Surgeons five years ago as a result of Dr. Joseph's complaint that members of the hospital staff were engaging in fee splitting, ghost surgery and unnecessary surgery. Following investigation the hospital was given a clean bill of health, it was reported.

The plaintiff's attorney described Barbour as the "guiding genius" of an alleged conspiracy to malign the surgeon's integrity, honesty and ethical conduct.

Attorneys for the hospital, Barbour and 16 other doctors, nurses and trustees named in the complaint said that failure to renew Dr. Joseph's appointment was the result of his unwillingness to comply with rules and regulations of the hospital, particularly those concerning operations.

Booklet Advances Cause for Degrees in Nursing

NEW YORK. — The advantages of a college degree in nursing are pointed up in a booklet titled "The College Way to a Nursing Career," published recently by the committee on careers of the National League for Nursing.

The text sketches technicalities of college entrance, outlines student life and activities, and emphasizes the rewards to be gained from a college course.

Some of these include: better preparation to take part in ever-increasing scientific activities of nursing, such as studies of cancer, research into drugs for mental illness, and advances in care of disturbed children; greater ability to impart some knowledge of medical science to patients; improved chances to participate in planning, supervision and management, and better foundation for carrying on advanced study.

Copies of the 20 page pamphlet are available from the Committee on Careers, National League for Nursing, 2 Park Ave., New York 16.

X-Ray Film Identifies Newborn Child Beyond a Shadow of a Doubt

CHICAGO.—At least one "mixed-up" newborn infant was returned to its rightful parents because of a radiologist's skill in interpreting shadows on an x-ray film.

The story was told in a recent issue of *Radiology*, publication of the American College of Radiology.

The incident, which occurred in a Hagerstown, Md., hospital, began when it was discovered that two newborn children and all four parents were of an identical blood type. This made it impossible to establish identity by matching blood types.

On April 6, baby girl No. 1 was brought to the hospital nursery from the delivery room. Her physical condition was such that back and front x-ray films of her chest were desired, and the radiologist discovered an enlarged thymus. There were no other abnormalities.

On April 11, baby girl No. 2 was admitted to the hospital nursery. The mother's initial was the same as that of the mother of baby No. 1.

On April 12, the mother of baby No. 1 was discharged from the hospital while the daytime supervisor of the nursery was off duty. A second nurse, not knowing there were two infants with the same name, took the first one she saw—and it was baby No. 2, the wrong one.

The mother who was going home didn't recognize the difference, and she left the hospital. She had seen her child only fleetingly during the hospital stay because it was not breast fed, which accounted for her lack of recognition.

The nursery supervisor, when she returned, recognized the situation and advised hospital administrative authorities. The mother was informed of the error and she returned to the hospital for positive identification of her own child.

Then it was discovered that the blood types of both sets of parents were the same.

The radiologist, learning of the dilemma, pointed out that an x-ray had been taken of baby No. 1 and that an enlarged thymus was present. X-rays of both infants were compared with the earlier film. Baby No. 2 had a normal thymus.

The identity of each child was thus positively established.

McCrimmon Elected by Florida Association

JACKSONVILLE, FLA. — Steve F. McCrimmon, administrator of Doctors' Hospital, Coral Gables, Fla., was named president-elect of the Florida Hospital Association at its 29th annual meeting here in December.

Other officers include the president, Ben P. Wilson, administrator, Munroe Memorial Hospital, Ocala, and the secretary-treasurer, Robert E. Rafnel, administrator of Tallahassee Memorial Hospital.

V.A. Frees 1700 Beds

WASHINGTON, D.C. — Approximately 1700 beds have been freed in Veterans Administration hospitals since August 1952 by transfer of elderly, chronic mental patients with physical illnesses to V.A. general medical and surgical hospitals that give special care to aged patients, according to Dr. J. F. Casey, director of the psychiatry and neurology service at the V.A. central office here.

COMING EVENTS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Schroeder Hotel, Milwaukee, Oct. 7-10.

AMERICAN COLLEGE OF OSTEOPATHIC HOSPITAL ADMINISTRATORS, St. Louis, Oct. 26.

AMERICAN HOSPITAL ASSOCIATION, national convention, Convention Hall, Atlantic City, N.J., Sept. 30-Oct. 3.

AMERICAN MEDICAL ASSOCIATION, Congress on Medical Education and Licensure, Palmer House, Chicago, Feb. 10-12.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, St. Louis, Oct. 27-30.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Palmer House, Chicago, Feb. 27-Mar. 1.

AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS, Palmer House, Chicago, June 22-29.

AMERICAN SOCIETY OF X-RAY TECHNICIANS, international convention, Sheraton Park Hotel, Washington, D.C., June 8-13.

ASSOCIATION OF MILITARY SURGEONS OF THE UNITED STATES, Hotel Statler, Washington, D.C., Oct. 28-30.

ASSOCIATION OF OPERATING ROOM NURSES, Hotel Statler, Los Angeles, Feb. 18-20.

ASSOCIATION OF WESTERN HOSPITALS, Statler Hotel, Los Angeles, May 6-9.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 4, 5.

CATHOLIC HOSPITAL ASSOCIATION, Statler Hotel, Cleveland, May 27-30.

CONFERENCE OF CATHOLIC SCHOOLS OF NURSING, 10th annual meeting, Statler Hotel, Cleveland, May 25-26.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Convention Hall, Atlantic City, N.J., May 22-24.

KENTUCKY HOSPITAL ASSOCIATION, Phoenix Hotel, Lexington, Mar. 26-28.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D.C., Nov. 18-20.

MASSACHUSETTS HOSPITAL ASSOCIATION, Hotel Statler, Boston, May 9.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 22-24.

MID-WEST HOSPITAL ASSOCIATION, Hotel President, Kansas City, Mo., April 24-26.

NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION, Ambassador Hotel, Atlantic City, N.J., April 29-May 3.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Palmer House, Chicago, Feb. 26-28.

NEW ENGLAND HOSPITAL ASSEMBLY, Statler Hotel, Boston, Mar. 25-27.

NEW MEXICO HOSPITAL ASSOCIATION, Hilton Hotel, Albuquerque, Mar. 11-13.

NEW YORK STATE DIETETIC ASSOCIATION, Hotel Utica, Utica, N.Y., May 2, 3.

OHIO HOSPITAL ASSOCIATION, Hotel Cleveland, Cleveland, Mar. 31-April 4.

SOUTH DAKOTA HOSPITAL ASSOCIATION, spring conference, Marvin Hughitt Hotel, Huron, April 15, 16; fall meeting, Sheraton Cataract Hotel, Sioux Falls, Oct. 15, 16.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta Biltmore Hotel, Atlanta, Ga., April 24-26.

TENNESSEE HOSPITAL ASSOCIATION, Mountain View Hotel, Gatlinburg, May 30-June 1.

TEXAS HOSPITAL ASSOCIATION, Shamrock-Hilton Hotel, Houston, May 14-16.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 29-May 2.

UPPER MIDWEST HOSPITAL CONFERENCE, Auditorium, Minneapolis, May 22-24.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Chamberlin, Old Point Comfort, Nov. 15, 16.

WEST VIRGINIA HOSPITAL ASSOCIATION, Greenbrier Hotel, White Sulphur Springs, Aug. 1-3.

Government Establishes New Traineeship Program

WASHINGTON, D.C. — The Public Health Service will help 650 to 700 graduate nurses who are continuing their professional education this year under a new program enacted at the last session of Congress.

Under this Professional Nurse Traineeship Program, grants totaling nearly $2 million have been made to 56 schools of nursing and public health in the United States and Puerto Rico. The schools are using these grants to award traineeships to qualified nurses enrolled in courses in nursing administration, supervision and teaching.

Mary Jenney, a senior nurse officer in the Public Health Service Commissioned Corps, has been appointed to head the program.

British Doctors Call Off Wage Strike—Temporarily

LONDON. — British doctors temporarily called off a strike against the National Health Service, which they had threatened if the government failed to increase their pay.

Representatives of the British medical profession and the Ministry of Health met early last month to discuss a demand by doctors for a pay increase of $1,492.40 a year. The doctors' "action committee," the British Medical Guild, said it was ready for a wholesale withdrawal from the health service if the demand were not met. At a press conference following the meeting, the negotiating committee, representing the 40,000 physicians and surgeons involved, said the Minister of Health informed them that the government cannot afford to grant the salary increase at this time.

The negotiating committee said no strike would be launched before the health minister had had an opportunity to confer with other members of his department.

The doctors made it clear, however, that "strike machinery" prepared by the British Medical Guild is still in existence. Spokesmen made it clear that, if there is a walkout, persons under treatment will continue to receive medical attention.

British physicians presently average $6,221.60 a year. The increase would bring their salaries to $7,714.

Centennial in Cincinnati

CINCINNATI.—Drs. Paul Dudley White and Walter Alvarez will be among speakers at the centennial celebration of the Academy of Medicine of Cincinnati, February 27 to March 5.

ABOUT PEOPLE

(*Continued From Page 79*)

The Rev. Marvin H. Ewert, who has served as chaplain of Bethel Deaconess Hospital and Bethel Home for Aged, Newton, Kan., since 1955, has been appointed administrator of the Bethel institutions. He succeeds **H. J. Andres,** who resigned. At the same time it was announced that **Omar Voran,** chief accountant and controller, will become assistant administrator of the institutions.

Byron Whitford has been appointed administrator of Doctors Hospital, Omaha, Neb. He succeeds **Josephine Dorsey,** who will remain as superintendent of nurses.

Kenneth Meredith is the new administrator at Cafaro Memorial Hospital, Youngstown, Ohio, succeeding **Elinore R. Font.**

Lester Johnson has been named administrator of Willmar State Hospital, Willmar, Minn. Mr. Johnson formerly was assistant superintendent at Baptist Hospital, Alexandria, La.

Paul T. Sodt has been appointed assistant administrator of Protestant Deaconess Hospital, Evansville, Ind. He formerly was administrator of Memorial Hospital, Oconomowoc, Wis. Mr. Sodt is a graduate of the State University of Iowa program in hospital administration.

Richard D. Edmondson has been named administrator of the Baker County Hospital, MacClenny, Fla., which is now under construction.

Arnold Hanson has been appointed administrator of North Broward General Hospital, Fort Lauderdale, Fla. Mr. Hanson formerly was associated with Spartanburg General Hospital, Spartanburg, S.C.

Frank Baker has been named assistant administrator of American Fork Community Hospital, American Fork, Utah. A registered x-ray technologist, Mr. Baker formerly was in charge of the hospital laboratory.

Dr. Lloyd B. Andrew, manager of the Veterans Administration Hospital at Birmingham, Ala., has been appointed manager of the V.A. hospital, Fayetteville, Ark. Dr. Andrew succeeds **Dr. Hursel C. Manaugh,** whose death was reported in the January issue of The MODERN HOSPITAL. **Dr. John S. Herring,** manager of the V.A. hospital, Montgomery, Ala., will succeed Dr. Andrew in Birmingham. Dr. Herring's position in Montgomery will be filled by **Dr. Thomas L. Harvey,** who has been director of professional services at the V.A. hospital in Lake City, Fla.

Sister Olive Cullenberg, administrator at Immanuel Hospital, Omaha, Neb., for the last nine years, has accepted an assignment to Trinity Hospital, Ashland, Wis. **Sister Ingeborg Blomberg,** assistant administrator, succeeds Sister Cullenberg.

Clover Uselton has been named administrator of Major Clinic Hospital, Nocona, Tex. She succeeds **Blanche Thompson, R.N.**

Louis Cunningham has been appointed administrator of Hamlin Memorial Hospital, Hamlin, Tex., succeeding **Wesley M. Nail.**

Sister Mary Agnelis has been appointed administrator of Yorktown Memorial Hospital, Yorktown, Tex., succeeding **Sister Mary Monica.**

B. L. Ramsey has been appointed business manager of Seminole Memorial Hospital, Sanford, Fla.

Edward J. Walsh has been appointed executive director of French Hospital, New York. He succeeds **Raymond Fay.**

Department Heads

Sister M. Raymond, a recent graduate of the public health nursing course at Marquette University, has returned to St. Margaret's Hospital, Kansas City, Kan., to help develop and reestablish the outpatient department for medical, surgical, maternity, child health, and orthopedics.

Wilma D. Fowler, R.N., has been named director of nurses at South Florida Baptist Hospital, Plant City, Fla. Mrs. Fowler succeeds **Paula Woods, R.N.** She formerly was associated with Grady Memorial Hospital, Atlanta, Ga.

Clara Smith, R.N., has been named director of nursing at Lincoln General Hospital, Lincoln, Neb. Miss Smith succeeds **Thora Patterson, R.N.,** who resigned to accept a position at the University of Tennessee Research Center.

Miscellaneous

Antone G. Singsen, associate director of the Blue Cross Commission, Chicago, has been appointed vice president in charge of operational functions, and **J. Douglas Colman,** vice president of Johns Hopkins University and Hospi-

Antone G. Singsen

J. Douglas Colman

tal, Baltimore, has been named vice president of the Blue Cross Association with primary responsibilities in public relations and research, it has been announced by Dr. Basil C. MacLean, as-

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sociation president. The recently reorganized Blue Cross Association will act as the national spokesman for its members, the local nonprofit Blue Cross plans, dealing with national problems affecting the hospital care prepayment program.

Mr. Singsen has been associated with national Blue Cross affairs for the last 12 years. In 1939 he was appointed public relations director of the Rhode Island Blue Cross Plan and headed the public information department of Connecticut Blue Cross from 1942 to 1943. He went to the Blue Cross Commission as assistant to the director of public relations, was promoted to assistant to the director of the commission, later became assistant director, and for the last two years has been associate director.

Mr. Colman has been closely associated with the Blue Cross movement since 1935, when he became executive secretary of the Hospital Council of Essex County, New Jersey. He later became director of the Hospital Service Plan of New Jersey (Blue Cross) and in 1938 was appointed executive director of the Maryland Hospital Service (Blue Cross). He was chairman of the Blue Cross Commission from 1948 to 1950. He has been at Johns Hopkins since 1951.

Thomas E. Edney has been appointed executive director of the New Hampshire-Vermont Blue Cross and Blue Shield Plans, succeeding **Russell S. Spaulding.** Mr. Spaulding, who had been named to the newly created post of executive consultant of the New Hampshire-Vermont organization, died December 26. He was 57 years old. Mr. Edney has been associated with Blue Cross-Blue Shield since 1947 and is a graduate of the Blue Cross-Blue Shield executive training program at the University of Michigan.


Ted O. Lloyd

Ted O. Lloyd, administrator of Phelps County Memorial Hospital, Rolla, Mo., has been selected the full-time executive director of the Missouri Hospital Association. The association office will be located in Jefferson City.

Edgar H. Clapp has been named associate director of the Rhode Island Blue Cross. He has been assistant director since 1944. At the same time it was announced that **Arthur F. Hanley** will become the new assistant director.

Clarice D. Gullickson, dietetic specialist with the Veterans Administration for the last 20 years, has been named director of a program in dietetics for the state of Pennsylvania. She will direct the special study of food service in state institutions from Pennsylvania State University, where she also will serve as professor of hotel and institution administration.


Dr. R. B. Crawford

Dr. Russell B. Crawford, superintendent of Lakewood Hospital, Lakewood, Ohio, for the last 16 years, has been appointed assistant director in charge of medical relations for the Cleveland Hospital Service Association. Dr. Crawford holds a medical degree from Northwestern University and practiced medicine in Lakewood for 21 years before his appointment as superintendent of Lakewood Hospital in 1940. He was president of the Ohio Hospital Association in 1951.

(*Continued on Page* 161)


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Bibliography of approximately 300 Xylocaine references upon request.

*Southworth, J. L., and Dabbs, C. H.: Xylocaine: a superior agent for conduction anesthesia, Anesth. & Analg. *32*:159 (May-June) 1953.

Astra Pharmaceutical Products, Inc., Worcester 6, Mass.


Dr. John Gorrell

Dr. John Gorrell, for the last three years a consultant to and director of medical services for the National Foundation for Infantile Paralysis, has returned to full-time consultation in hospital administration and community health studies. From 1945 to 1953, Dr. Gorrell was professor of hospital administration in the school of public health at Columbia University. He is a member of the American Association of Hospital Consultants and a fellow in the A.C.H.A.

Dr. Jean A. Curran has been appointed full-time consultant to the trustees of the Bingham Associates Fund, with an office in New England Center Hospital, Boston. Formerly associate executive dean for medical education at the State University of New York, Dr. Curran will survey the activities of the Bingham Associates Fund. Dr. Curran has been a trustee of the New England Center Hospital since its establishment in 1949. He was dean and president of the Long Island College of Medicine from 1937 to 1950 and continued as dean after 1950 when it became part of the State University of New York.

Majeane Werschkul has been named assistant secretary of the Oregon Association of Hospitals. Mrs. Werschkul will assume many of the duties of the former executive secretary of the organization, **Ralph W. Nelson,** who resigned to become associate administrator of Collis P. & Howard Huntington Memorial Hospital, Pasadena, Calif.

Lynn C. Wimmer has been named managing editor of *Hospital Administration,* the new quarterly journal of the American College of Hospital Administrators. Mr. Wimmer was at one time assistant public relations director of the American Hospital Association. Most recently he has been vice president in charge of public relations for Burton Browne Advertising, Chicago.

Deaths

Dr. Eugene W. Martz, 58, former assistant director of Letchworth Village, a state medical hospital near Haverstraw, N.Y., died December 28 in Stony Point, N.Y. Dr. Martz received his medical degree from the college of medicine at Ohio State University in 1925.


William O. Bohman

William O. Bohman, 42, administrator of Middletown Hospital, Middletown, Ohio, since 1953, died January 13 of injuries suffered in an automobile accident January 4. Mr. Bohman formerly had been administrator of Norwegian-American Hospital, Chicago, from 1947 to 1953. He was a graduate of Augustana College and also attended the University of Chicago. He was a fellow of the American College of Hospital Administrators and chairman of the hospital safety committee of the National Safety Council.

Professor-Emeritus C-E. A. Winslow, 79, an expert in public health and first chairman of the department of public health of Yale University School of Medicine, died January 9 in New Haven, Conn. Dr. Winslow had retired in 1945 after 30 years at the university. In 1915 he went there as the Anna M. R. Lauder professor of public health and as first chairman of the department.

THE BOOK SHELF

THE COST OF THE NATIONAL HEALTH SERVICE IN ENGLAND AND WALES. *By Brian Abel-Smith and Richard M. Titmuss, National Institute of Economic and Social Research, Cambridge University Press,* 1956. *Pp.* 173. $5.50.

I have just read a report of the British National Institute of Economic and Social Research, which I took up because of interest in the British National Health Service. But before the reading had been completed, I found contributions to hospital service in general which should intrigue us in America.

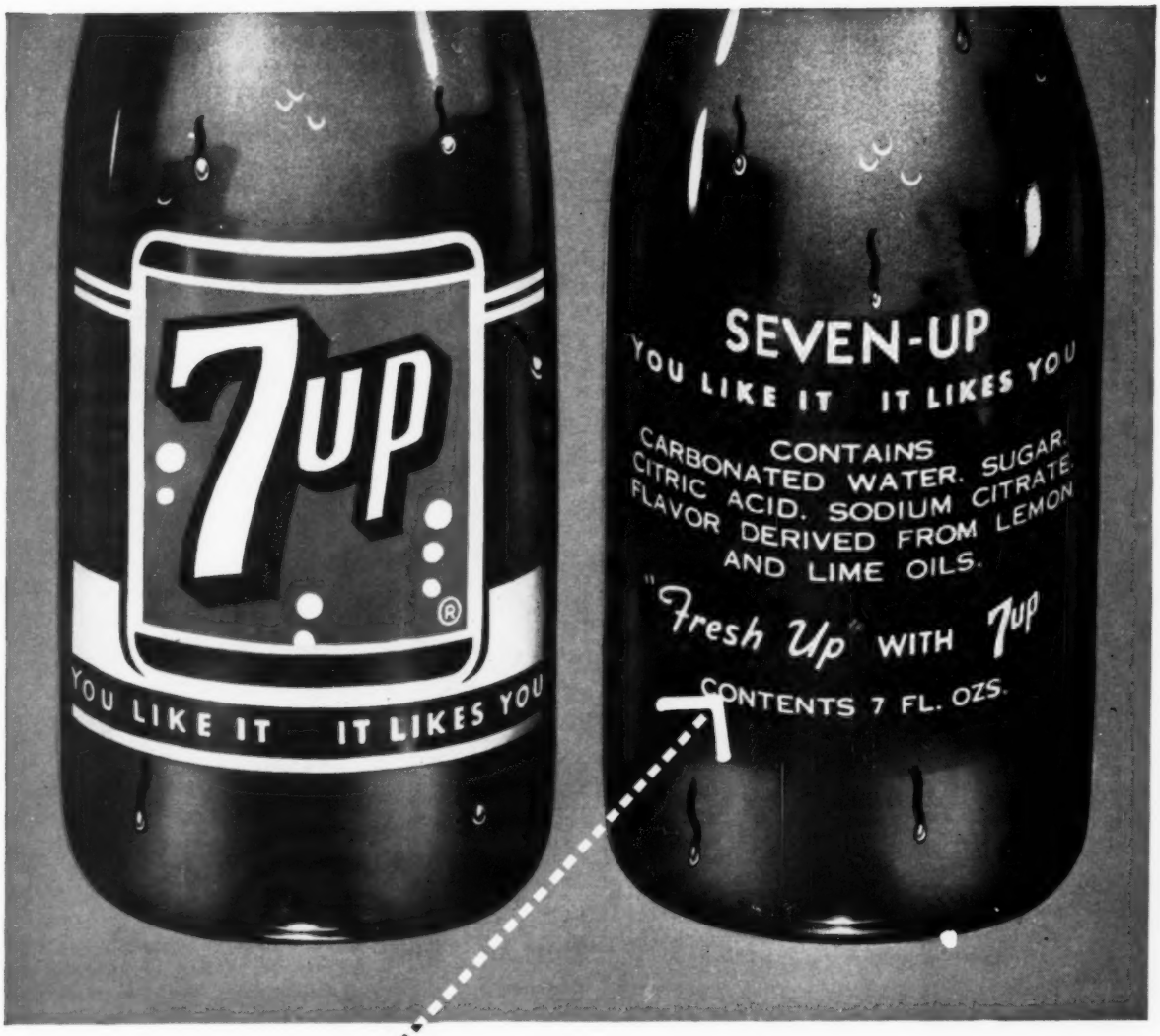
In England as in this country, the increase of elderly persons in the population has given concern to hospital people, as well as to economists and officials. Since persons over 65 have on the average more illness than young people, and especially more chronic illness, will not continued growth in the proportion of elderly persons fill future beds in hospitals and nursing homes with "long-stay cases," many of whom cannot pay their own way?

The National Institute, a privately supported agency, was asked by a responsible government official to make a careful study of the cost of the National Health Service, a subject considerably controverted since the Service was started in July 1948. This book, by two British scientists of distinction, is the result—a report of 73 pages, with informative appendices running to another hundred.

Some medical writers and political speakers in Britain have expressed the fear that the National Health Service will "wreck the national economy" because of its growing cost, attributed largely to the increased number of elderly people. Hence the authors gave especial attention to this issue.

Their study does not support this doleful conclusion. On the contrary, they conclude that the expected changes in the population of England and Wales "by themselves are not likely to exert an appreciable effect on the future cost of the National Health Service." The data on which this conclusion is based challenge us in the United States to find out whether the facts and trends here are similar or dissimilar.

The essential facts are that the use of both acute and chronic hospitals by elderly persons is greatly affected by



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marital and social status. These factors override the age factor. Specifically, cross-section study of the patients in all types of hospitals in England and Wales showed the following perhaps surprising facts:

"Compared with the demands made by single men and women (and to a lesser extent, the widowed), the proportion of married men and women in hospitals even at age 65 and over is extremely small.

"Among married men and women, the rise in the proportion in hospitals with advancing age is not at all dramatic; it does not reach very high levels even after age 75.

"For all types of hospitals and in relation to their numbers in the total adult population, the single, widowed and divorced make about double the demand on hospital accommodation compared with married people.

"About two-thirds of all the hospital beds in the country occupied by those aged over 65 are taken by the single, widowed and divorced.

"The bulk of the population of mental and 'chronic' hospitals are single people. Of the single and widowed men and women aged over 65 needing hospital care, most are to be found in these two types of hospital. The married state appears to be a powerful safeguard against admission to hospitals in general and to mental and 'chronic' hospitals in particular.

". . . a higher proportion of the cost of the National Health Service is devoted to the medical care of the under 15 age group (including confinements) than to the medical care of persons aged 65 and over."

According to the official estimates of the future population of England and Wales, the proportion of over 65 persons who are married will increase during the next 15 years, whereas "the number of single women of pensionable ages will actually decline, while the number of single men of such ages will increase by only a negligible figure." Quantitative analysis of these population trends leads thus to the conclusion that, taken by themselves, the expected changes in age structure of the British population, up to 1971, will increase the current cost of the National Health Service (which includes hospitalization of all types for nearly all of the people) by only 3.5 per cent.

Is the marital state on this side of the Atlantic as important as it seems to be in England in keeping people out of hospitals? Let us hope for studies that will answer this question as to both short-term and long-term hospitalization. The answer may not be the same as in Britain and the answers may vary in different parts of our much larger and more varied country. To know the effect of these social factors on the demand for hospital care is obviously of first-rate medical, social and economic importance.

It is a pity that the report did not cover medical factors which also may have great effect on hospitalization in the future. How much, for example, will improved therapy reduce the admission rate to mental hospitals and the length of stay therein? How may future advances in diagnosis and treatment — including new antibiotics — lessen the need for certain surgery or the amount of hospitalization in cardiac diseases or arthritis? The authors recognize these factors, but plead that shortness of time and lack of funds prevented evaluation of them.

Something may be added about other parts of this report. The increases in the cost of the National Health Service since 1948 have been due mainly to

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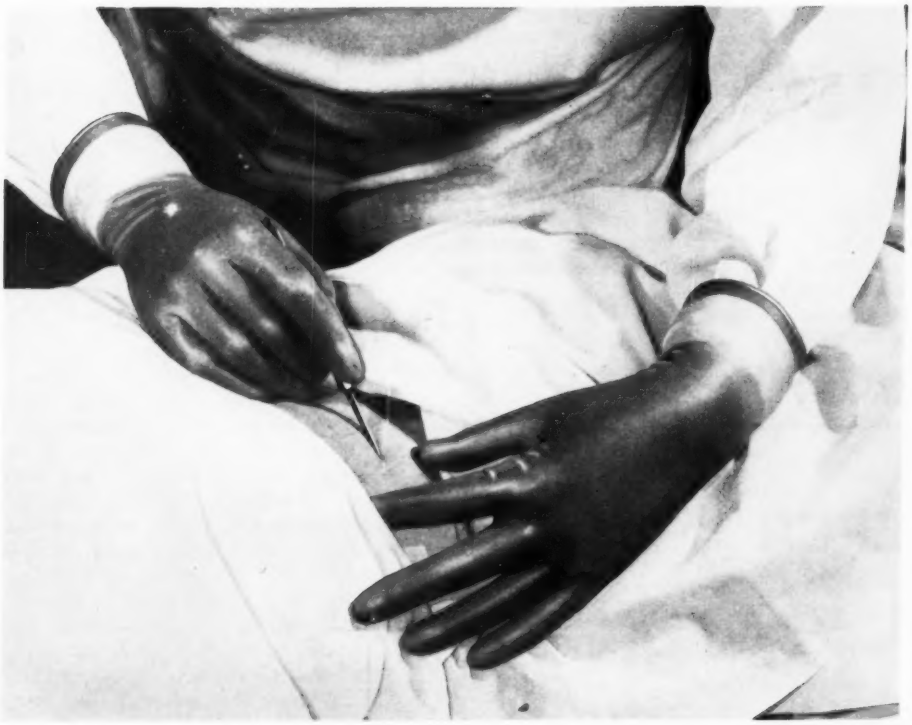
GENERAL ELECTRIC

rise in the expenditure for hospital services. Since the first full year of the service (1949-50), the rise has been 37 per cent. In Britain, as with us, hospital costs have been mounting. More than half (58 per cent) of the rise in hospital expenditures is attributed by the report to higher prices, but there have also been substantial additions to the medical, nursing and other staffs taking care of patients. There are significant studies of the use of part-time and whole-time medical staffs and the consequent effects on costs. The part-time are more costly. Another element making for increase in hospital costs is the growing amount of medical work done in the hospitals on both bed and ambulatory patients, which was formerly performed in the doctor's office or in the patient's home. In Britain, as with us, this change represents a transfer of costs from private office practice to salaried practice in hospitals, and swells hospital budgets instead of appearing as expenditures of consumers.

The review of capital expenditures for hospitals shows, as would be expected, that the immense demands for funds to replace or restore homes and other buildings damaged during the war has starved the British hospitals. "Approximately 45 per cent of all hospitals (in England and Wales) were originally erected before 1891; many are regarded by expert opinion as seriously in need of replacement. For this to be achieved in any measurable period, the present rate of capital expenditure would have to be multiplied several times."

American readers will observe how this report relates expenditures for hospitals, physicians, drugs and other health services to the economy of the nation as a whole. First, the effect of general price increases is considered; second, the growth of population during the five-year period; third, the age structure of the population as already discussed; and finally, the growth of the national economy as measured by increase in "gross national product." When the rise in general prices and the population changes are all allowed for, the unit cost, *i.e.* per capita of population, of the National Health Service was practically the same at the end of the five years as at the beginning and the percentage of total current national resources devoted to health services dropped from 3.75 per cent to 3.25 per cent. Analyses of this kind might help hospitals and physicians on



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this side of the water.—MICHAEL M. DAVIS.

ORGANIZED HOME MEDICAL CARE IN NEW YORK CITY. *A Study of 19 Programs of the Hospital Council of Greater New York. A Commonwealth Fund Book, Harvard University Press,* 1956. *Pp.* 538. $8.

This report covering the city of New York, issued by the hospital council of that city, could not help but give a somewhat bewildering view of this many-faceted program (19 in all, each one different from the others) which stems from the pioneer project in Montefiore Hospital. When I first promulgated the idea of home care in the early Forties it was with the clearly publicized recommendation that it be *an extramural hospital service integrated with its intramural service and continuous with it in all directions.*

Because of personal ambitions, unreasoned opposition to hospital authority in certain quarters, and distrust and suspicion of this new concept which calls for responsive and responsible medical care at all times and in all places—apart from misunderstanding of its purposes—concessions have been made to expediency. The feeling seemed to be that the program was of such a high order that it must be established in some form at all costs, even by compromises with quality, continuity and responsibility.

Since the basic idea was excellent, men hurried to give it effect, yielding valuable ground as organization and administration proceeded. The most serious concession occurred in the detachment of the program from hospital auspices (meaning hospital quality) and its integration with prevailing welfare activity in home medical care. Under this system, hospital cooperation during a period of acuteness must be sought on short notice at a later date when the detached authority could act as middleman in purveying medical care. In this way the hospital, by permitting the transfer of initiative, lost a valuable asset and, as a result, a stimulant to better social-medical care on both sides of its walls.

Whatever the facts, this book reflects the variety of programs now in vogue, each of which is analyzed tactfully and its shortcomings left to the reader. What emerges from all of this labor is a tacit reaffirmation of the pioneering Montefiore idea. There is, therefore, some hope that hospital leadership will respond more affirmatively and that future programs will follow the original example, overcoming obstacles by a patient, understanding, statesmanlike approach to all potential participants in an effort to prove to each of them that the extramural program of hospital service is in his best interest as well as the best interest of the patient.

It is of some significance that many jumped on the band wagon when the original home care program was announced, and later when the salesmen moved into the saddle. They suddenly discovered that they had also been running—since 1796! As a matter of fact, home care of one kind or another has been practiced from the earliest times, and pious words have been uttered on the subject, but never in the tightly integrated form of the original extramural program which was such a true reflection of the principles of modern social medicine. The professors of the faculty of Louvain taught medical students in the homes of patients, as they did at St. Peter's Hospital, 500 years ago!

In the pages of this book it becomes clear that the integrated extramural

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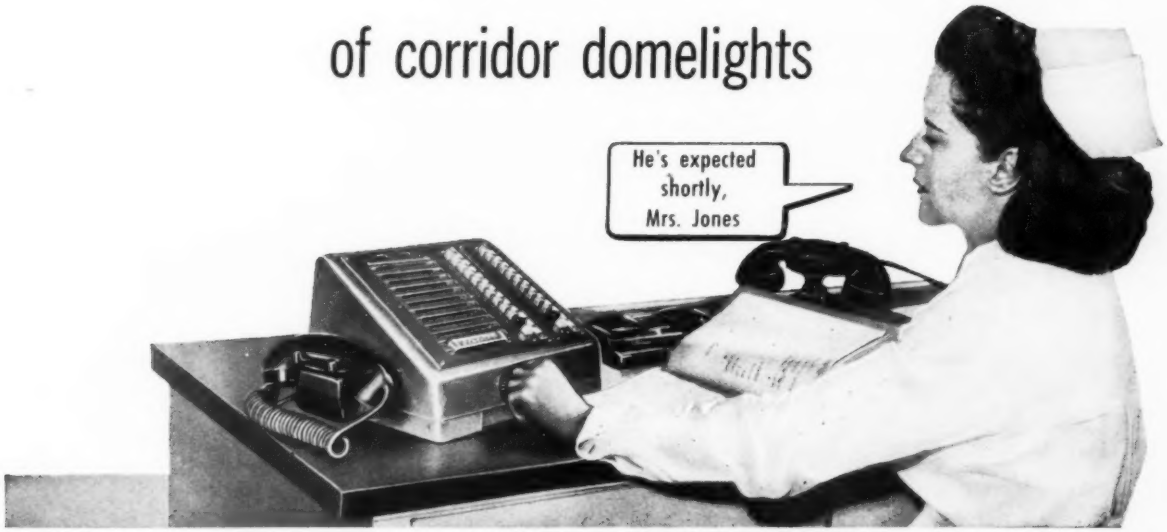

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idea has had a strong influence on medical care generally and on the stepchildren of the idea specifically, producing some inspired leadership in the process. It also becomes clear that the hospital will, after all is said and done, eventually accept its rightful place of leadership in this new area of medical activity.

This book is a refreshing contrast to the distorted and unscholarly "Public Health Monograph 35" which deals with the subject on a wider geographic basis. Credit for this better product must go to the young and devoted scholar who directed this study, Dr. Peter Rogatz, and to his excellent associates.—E. M. BLUESTONE, M.D.

KENNY VISITS THE HOSPITAL. *By Julia Ann Bartosh, R.N., Exposition Press, New York City,* 1956. *Pp.* 62. $2.50.

Pediatricians, psychologists and others working with children in hospitals have had much to say about how to orient the young patient to hospital procedures. Certainly this is an important subject for everyone concerned with pediatric departments.

Julia Ann Bartosh, R.N., in "Kenny Visits the Hospital," has indeed provided an effective instrument for those interested in making life a little easier for children undergoing hospital treatment.

The following statement from Exposition Press Inc., publishers of this book, is of particular significance: "Children naturally fear the unknown, just as adults do, but this fear is magnified by separation from family and fears of adults in white, of anesthesia, preoperative routine, the operating room, the various jabs and punctures connected with transfusions, injections, enemas and temperature taking. To avoid hospital shock, to prevent lasting emotional scars on the child, parents must allay these fears by not communicating their own apprehensions, by knowing what to expect, and by answering all questions put to them by their youngsters honestly, sensibly, and accurately."

Miss Bartosh's book portrays through pictures and brief textual material the story of a little boy entering the hospital for surgical treatment. From her deep understanding of child psychology and fears and because of her sincere interest in helping all children, Miss Bartosh has made a most valuable contribution to the cause of proper handling of children before and during their hospital experience.

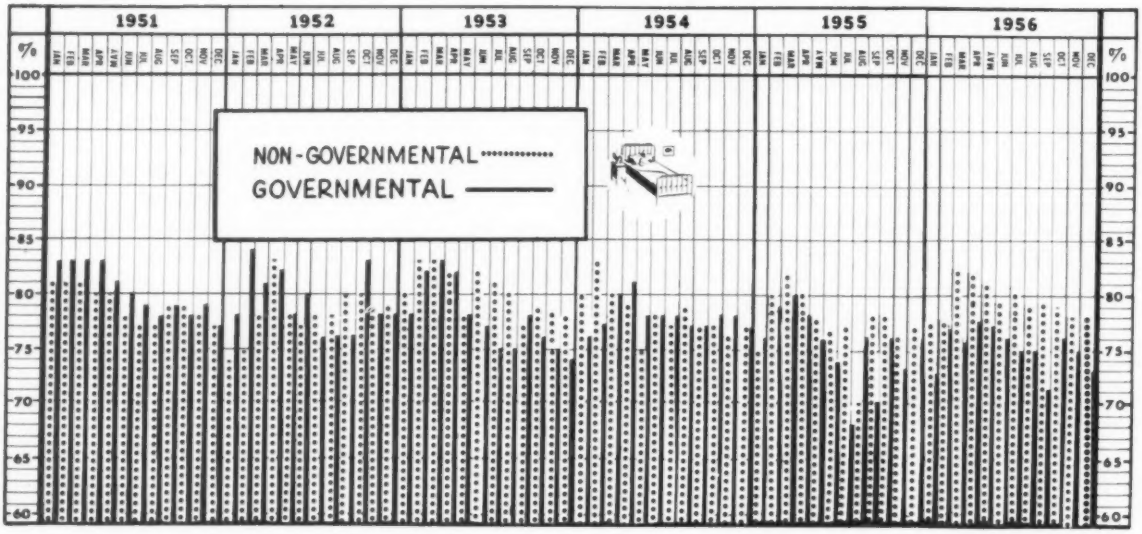
The pictures and text of this excellent little book carry the young patient, Kenny, from the doctor's office checkup through every phase of his hospital admission and treatment. As a matter of fact, this book will give many adults a far better appreciation of what it takes to provide modern hospital care than they have had before.

Dr. J. Shirley Sweeney, F.A.C.P., says in his foreword, "No more momentous experience exists than a child's first visit to a hospital, especially to undergo a surgical operation. Fear is basic; fear of doctors and hospitals is more than usual. Few parents have overcome these fears in their children."

I believe that if every child could look at the pictures and either read the text or have it read to him by his parents before entering the hospital, many of his fears and doubts would be banished.

Pediatricians would do well to present a copy of this book to any of their young patients for whom they have advised hospital admission.—EVERETT W. JONES.

Voluntary Hospital Occupancy Rises



Voluntary hospitals reported occupancy at 78.1 per cent of capacity for the month of December 1956. Government hospitals were 73 per cent occupied, according to figures submitted to the Occupancy Chart. Percentages reported for December 1955 were 75.5 and 71.3, respectively.

From the period December 12 to January 7, construction totaled $45,101,220. For the similar period last year, $21,554,950 was reported.

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ANESTHETIST—Male, M.D.; many years experience in all phases of anesthesia; available immediately; salary or fees. Apply MW 131, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

FOOD ADMINISTRATOR—Would like position in large institution; ten years experience; furnish good references on request; age 34, married, veteran, 2 years college. Apply MW 128, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

FOOD ADMINISTRATOR—Complete knowledge purchasing, payroll control, portion control, preparation and upgrading of food quality and service; hotel, hospital and institution background; top references. Write MW 131, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

LIBRARIAN—Medical record; registered; B.A., seeks association with outstanding hospital, research unit, or public health agency in or near New York City; varied medical records background includes teaching, abstracting, surveying; excellent work references. Apply MW 130, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

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ADMINISTRATOR — Medical; MPH (Yale); eight years, assistant superintendent, 1200-bed general hospital; three years, administrative staff, one of leading organizations in graduate medicine.

ADMINISTRATOR—MPH (Hospital Administration) Yale; four years, assistant administrator, 400-bed hospital.

ANESTHESIOLOGIST—Diplomate; eight years, private practice and director department, 200-bed hospital.

COMPTROLLER—Eight years, chief accountant and business office manager, university hospital, 800-beds; will consider assistant administratorship.

DIRECTOR OF NURSING — M.S. (Nursing Service Administration); four years, assistant director, nursing service, 300-bed hospital.

FOOD SUPERVISOR — B. S. (Major: Hotel and Restaurant Management); excellent experience.

PATHOLOGIST—Diplomate, three years, associate pathologist, teaching hospital and on faculty medical school as associate professor.

RADIOLOGIST—Fellowship, university center; several years' successful private practice; Diplomate (Diagnostic and Therapeutic X-ray and Radium Therapy).

MEDICAL BUREAU—*Continued*

SOCIAL WORKER — B.A., M.S.W. (Major: Medical Social Work); five years, consultant, state department of social welfare.

ADMINISTRATOR—B.S., M.P.H., trained 2 years, teaching hospital; past 3 years, administration 225-bed JCHA hospital; late 30's; Member ACHA.

ADMINISTRATOR — B.S. (Business Administration), M.S. (Hospital Administration). 5 years, hospital accounting, office and credit manager, 150-bed hospital; 18 months, assistant director, 1000-bed teaching hospital; any locality; early 30's.

ADMINISTRATOR—R.N.; past 6 years, administration, 50-bed hospital; seeks larger hospital, greater responsibility; midwest; Member, ACHA; excellent references.

ASSISTANT ADMINISTRATOR—B.S. (Business Administration); M.S. (Hospital Administration) year's residency, 600-bed hospital; three years, experience as assistant administrator then administrator, 450-bed hospital; consider assistantship, university affiliated hospital very large size; any locality; middle 30's; excellent references.

ASSISTANT ADMINISTRATOR—R.N.; B.S.; 37; several years nursing experience; 6 years assistant administrator 350-bed teaching hospital; seeks assistantship with greater responsibilities; known to us as outstanding man; excellent references; member ACHA.

ANESTHESIOLOGIST — 3 years, successful private practice; anesthesiology; 3 years, associate anesthesiologist, 250-bed teaching hospital; now seeks own department in larger hospital; any locality; also consider associateship, hospitals 500-beds up; middle 30's; Diplomate.

PATHOLOGIST—M.D. Iowa; A.O.A.; 4 years general practice before specializing; completing 4 years residency; pathology May 1957; requires town with Catholic schools; prefers Minnesota, Wisconsin, Dakotas, Michigan, Iowa; minimum $15,000; early 30's.

PATHOLOGIST—4 years training, pathology, university hospital; since 1953, assistant pathologist, important teaching unit pathology, large university medical center; well qualified, hematology; recommended as extremely capable, scientific, serious leader; 32; Diplomate, clinical anatomy.

PURCHASING DIRECTOR — 10 years, purchasing director 500-bed voluntary hospital; prefers Ohio only; early 40's; member NAPA.

RADIOLOGIST—5 years, associate radiologist, 650-bed, fully approved, JCAH voluntary hospital; middle 30's; Diplomate.

(Continued on page 176)

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
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Cleveland, Ohio

ASSISTANT ADMINISTRATOR — Age, 38 years; BBA Degree, M.S. Degree, Hospital Administration; Public accountant: 4 years purchasing agent, eastern hospital; will consider business management.

ADMINISTRATOR—M.A. Degree; 3 years experience assistant director, large teaching hospital; past 10 years administrator, 225-bed hospital; available.

ADMINISTRATOR—M.H.A. Degree; Age, 33 years; 4 years office manager; 2 years assistant administrator.

ADMINISTRATOR—B.S. Degree; (R.N.) 12 years director, personnel, eastern firm; presently administrator, 30-bed mid-western hospital; any location.

EXECUTIVE HOUSEKEEPER — 6 months course, housekeeping; 4 years housekeeper, residential club; 4 years housekeeper, eastern hospital; well recommended.

DIRECTOR, NURSING SERVICE—B.S. Degree; outstanding experience; desires mid-west or south.

SUPERINTENDENT—(R.N.) 7 years director, nursing service; 4 years superintendent, 120-bed hospital.

POSITIONS OPEN

ADMINISTRATOR — Bethesda Memorial Hospital of Delray Beach, about to begin construction on a 60-bed general hospital is now ready to employ an administrator and will be glad to receive applications from interested applicants. Apply to Catherine E. Strong, Box 441, Delray Beach, Florida.

ADMINISTRATOR or BUSINESS MANAGER —Experience necessary, salary open; 50-bed general hospital; Milwaukee area. Apply MO 159, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

ANESTHESIOLOGIST—Board eligible; wanted immediately; to join a group of 6 staff anesthesiologists. If available write or phone Stevens J. Martin, M.D., Director Department of Anesthesiology, St. Francis Hospital, Hartford 5, Connecticut.

ANESTHESIA NURSE—Experienced in practically new 118-bed approved hospital; 40 hour week, salary $450 to $500, fringe benefits. Apply R. R. Hobart, Administrator, Coffeyville Memorial Hospital, Coffeyville, Kans.

ANESTHETIST—Nurse; to join obstetrical anesthesia staff; 40 hour week; salary adjusted to experience. Write Administrator, Highland Hospital, Rochester, New York.

ANESTHETIST—Nurse; new 200-bed hospital; modern equipment, active department. Apply Administrator, Bradford Hospital, Bradford, Pennsylvania.

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ANESTHETIST—Male or female; new hospital; minimum of call, top salary. Apply St. Francis Hospital, 3237 S. 16th Street, Milwaukee, Wisconsin.

ASSISTANT DIRECTOR EDUCATION—Male or female; temporary accreditation; integrated program; M.S. in Education preferred; salary open. Apply MO 173, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ASSISTANT DIRECTOR NURSING SERVICE—Man or woman; J.C.A.H. approved; 230-beds; B.S. and successful experience in Nursing Administration; $4,800 plus meals; liberal personnel policies; Chicago area. Apply MO 172, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ASSISTANT DIRECTOR OF NURSES — To teach practical nursing students in a 250-bed geriatric home located in Chicago; Degree in nursing education required; salary depends on qualifications and experience; also interested in staff and supervisory nurses; excellent working conditions, 40-hour week with vacation, holidays, sick leave with pay and group insurance privileges; member of AHA. Call or write Director of Nursing, Orthodox Jewish Home For The Aged, 1648 So. Albany Avenue, Chicago 23, Illinois.

ASSISTANT DIRECTOR OF NURSING SERVICE—650-bed general hospital located in industrial city (300,000); primary responsibility to plan and supervise in-service program; experience and preparation in nursing service administration desirable. Write Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

ASSOCIATE DIRECTOR—635-bed medical center nursing school, 3 year diploma program, no affiliations; Master's degree; salary excellent. Write Director, Albany Medical Center, School of Nursing, Albany, New York.

ASSOCIATE MEDICAL DIRECTOR—100-bed tuberculosis hospital, North American graduate; salary $8500-9500; complete maintenance. Apply Medical Director & Superintendent. District One Tuberculosis Hospital, Madisonville, Kentucky, or State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

ASSOCIATE DIRECTOR OF NURSING—650-bed general hospital located in industrial city (300,000 population); all new facilities, hospital opened in 1954; experience required; Masters degree in Nursing Service Administration preferred. Write Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

DIETITIAN—Modern kitchen, 74 employees, liberal food budget, 600-bed fully accredited hospital; no nursing school; social security and State retirement; salary range $3,588-$4,428; liberal annual and sick leave privileges; member A.D.A. preferred. Apply MO 169, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIETITIAN—Chief; 120-beds; no school of nursing; salary $425 up; full supervision kitchen and therapeutics. Apply Jane S. Davis, Pawating Hospital, Niles, Michigan.

DIETITIAN—Assistants; food production or therapeutic; Teaching Hospital. Apply to Director, Department of Nutrition and Dietetics, University of Missouri, 807 Stadium Road, Columbia, Missouri.

DIETITIANS—Therapeutic dietitians; Barnes Hospital, large teaching hospital; 6 units affiliated with Washington University School of Medicine; beginning salary $325 per month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—A.D.A.; to head department; 100-bed general hospital; duties include cafeteria, general and therapeutic diet planning, patient contact, general supervising, teaching student nurses; maintenance available. Apply Hospital Administrator, St. Joseph's Hospital, Lewistown, Montana.

DIETITIAN—Registered; qualified to assume full department head duties if necessary; 156-bed general hospital located in central Ohio. Complete details upon request to Administrator, Marion General Hospital, Marion, Ohio.

DIETITIAN—Staff; therapeutic A.D.A. member to supervise tray service and related employees and patient contact for hospital completing expansion to 500-beds; entirely new department; dietetic program integrated with approved school of nursing; affiliated with medical research institute sick leave, social security, hospitalization insurance, 40 hour week, 2 weeks vacation, 6 holidays, etc. Contact Miss Rosemary Brown, Dietitian Director, Toledo Hospital, Toledo 6, Ohio, or telephone collect to Lawnsale 1121.

DIETITIAN—Therapeutic, assistant to chief; for a 306-bed teaching hospital with diagnostic clinic; a large full-time medical staff and house staff, salary open, progressive personnel policies. Apply Chief Dietitian, Geisinger Memorial Hospital and Foss Clinic, Danville, Pennsylvania.

DIETITIAN — Administrative, assistant to chief; for a 306-bed teaching hospital with diagnostic clinic; a large full-time medical staff and house staff, salary open, progressive personnel policies. Apply Chief Dietitian, Geisinger Memorial Hospital and Foss Clinic, Danville, Pennsylvania.

DIETITIAN — A.D.A.; therapeutic; 160-bed general hospital, college town, 20 miles west of Milwaukee; major expansion program to be started in spring of 1957; modern dietary department completely remodelled in 1954-55. Apply Personnel Department, Waukesha Memorial Hospital, Waukesha, Wisconsin.

DIRECTOR OF NURSING AND PRINCIPAL OF THE SCHOOL OF NURSING—Applications are invited for the above position at the Royal Columbian Hospital, New Westminster, (434-beds); duties consist of directing nursing services and accredited school of nursing of approximately 225 students; teaching and administrative experience required—prefer minimum of five years as director or assistant director experience; remuneration commmensurate with experience and responsibilities. Please reply fully giving details of nationality, training, experience, age, etc., to Secretary, Board of Directors, Royal Columbian Hospital, New Westminster, British Columbia, Canada, not later than March 15, 1957.

(Continued on page 178)

DIRECTOR OF NURSING SERVICE—64-bed general modern hospital, mild southern climate, northern Alabama; because of increased activity, well-qualified person needed; salary commensurate with experience and ability; paid vacation, holidays, sick leave, social security. Apply Thos. L. Qualey, Administrator, Athens-Limestone Hospital, Athens, Alabama.

DIRECTOR OF NURSING EDUCATION—For 262-bed tuberculosis hospital which is establishing affiliation nursing school; BS degree in nursing; teaching experience desirable; living quarters, vacation, sick leave and other benefits available. Apply to Director of Nurses, District Two State Tuberculosis Hospital, Bluegrass Ave., Louisville, Kentucky. Telephone Emerson 3-2643.

DIRECTOR OF NURSING SERVICE—200-bed general hospital in suburb of Washington, D.C. fully approved; no training school; new air-conditioned wing; salary open. Apply Suburban Hospital, Bethesda, Maryland.

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DIRECTOR OF NURSING EDUCATION—Diploma program; modern 70-bed hospital with full JCAH approval; students have 6 months pre-clinical special course at the University of Vermont and affiliations in psychiatry and pediatrics; situated in rural area, center of Vermont, about midway between Boston and Montreal. Salary open. Apply Administrator, Gifford Memorial Hospital, Randolph, Vermont.

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EDUCATIONAL DIRECTOR—Masters Degree and experience in teaching desirable; salary open, liberal personnel policies including 40 hour week, all cash salary, pension plan in addition to social security and hospitalization; living quarters available if desired; admit one class a year; three year diploma program; 300-bed hospital, 89 students; basic sciences taught at New Jersey Teacher's College; position open May 1957. Apply to Director of Nursing, The Mercer Hospital, Trenton, New Jersey.

EDUCATIONAL DIRECTOR—For accredited diploma school of nursing; 270-beds modern, accredited, general hospital and teaching institution for interns, residents, x-ray and laboratory technicians; school affiliation with Oberlin College and Metropolitan City Hospital for specialties; rapidly expanding community near universities, excellent personnel policies; living accommodations available if desired; salary commensurate to degree and experience. Write Director of Nursing, Elyria Memorial Hospital, Elyria, Ohio.

INSTRUCTOR—Clinical; operating room technique, 200-bed hospital; 40 hour week, 4 weeks vacation. For further information write Director of Nursing, Iowa Lutheran Hospital, Des Moines.

Foyer of Lutheran Hospital, St. Louis, Missouri, showing ceiling installation of Acousti-Celotex Celotone* Fissured Mineral Fiber Tile and Striatone† Striated Mineral Fiber Tile (both incombustible). **Architect:** Froese, Maack & Becker. **Acousti-Celotex Contractor:** Henges Company, Inc.

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CLINICAL instructure in medical and surgical nursing; approved school of 50 students; all approved policies; B.A. required; M.A. desired. Write Director of Nursing, Danbury Hospital, Danbury, Connecticut.

INSTRUCTOR—Clinical in obstetrics for diploma school of nursing; newly modernized obstetrical unit; 75 miles from New York City; good personnel policies, 40 hour week; experience in teaching obstetrics and degree in nursing education preferred; starting salary $400. Apply MO 164, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

INSTRUCTOR IN CLINICAL NURSING—For diploma school of nursing of approximately 90 students; good personnel policies; 40 hour week; experience in teaching and degree in nursing education preferred; starting salary $400. Apply MO 165. The Modern Hospital, 919 N. Michigan Avenue, Chicago II, Ill.

INSTRUCTOR—Clinical; in obstetrical nursing for both formal and clinical teaching; B.S. Degree and experience in teaching desirable; faculty being increased; liberal personnel policies; salary dependent upon qualifications and experience; admit one class a year, three year diploma program; 300-bed hospital, 89 students, position open for immediate appointment. Apply to Director of Nursing, The Mercer Hospital, Trenton 8, New Jersey.

INSTRUCTOR—Clinical pediatric nursing; Degree and experience in nursing of children required; school of nursing fully accredited; 650-bed non-profit hospital located in industrial city (population 300,000); 40 hour week; paid vacations; liberal benefits. Write Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

INSTRUCTOR—Pediatric clinical; for diploma school of nursing; pediatric unit approximately 20-beds; 1½ hours from New York City; 40 hour week; good personnel policies; experience in teaching in pediatrics and degree in nursing education preferred; starting salary $400. Apply MO 167, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

INSTRUCTOR — Clinical Pediatrics; 265-bed general hospital, pediatrics daily average 30; school enrollment 130; degree or working toward degree; experience; salary open, policies liberal. Apply Director of Nurses, St. Joseph's Hospital, Lancaster, Penna.

INSTRUCTOR FOR NURSES' AIDES—General hospital treating men, women and children; 128 adult and pediatric beds plus 24 bassinets; 40 hour week; salary open. Apply Director, Woman's Hospital, 1940 East 101st Street, Cleveland 6, Ohio.

INSTRUCTOR — Nursing Arts; B.S. Degree and experience in teaching desirable; salary dependent upon background and experience; liberal personnel policies; admit one class a year; three year diploma program; 300-bed hospital, 89 students; position open; have full time assistant instructor in this area. Apply to Director of Nursing, The Mercer Hospital, Trenton 8, New Jersey.

INSTRUCTOR—Psychiatric nursing; B.S. Degree required; $3300 yearly salary; furnished apartment, meals and laundry, 40 hour, 5 day week, paid vacation, 7 holidays and liberal sick leave; approximate starting date April 15. Apply Personnel Office, Mental Health Institute, Independence, Iowa.

INSTRUCTOR—Science; for diploma school of nursing; approximately 90 students; 75 miles from New York City; 40 hour week; good personnel policies; experience in teaching in science and degree in nursing education preferred; starting salary $400. Apply MO 168, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

LIBRARIAN—Registered medical records; to assume charge of record room in a 200-bed hospital near Boston; forty hour week; excellent fringe benefits; salary open. Apply MO 176, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

LIBRARIAN—Registered medical records; To head department; also, opening for assistant to chief of department, in accredited hospital of 296-beds and 36 bassinets; 40 hour week and salary open. Apply to Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

LIBRARIAN—Medical record; registered to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

LIBRARIAN—Medical record; required immediately as assistant; R.R.L. preferred; excellent personnel policies; health benefits available; Apply stating experience and salary desired to Personnel Director, Sarnia General Hospital, Sarnia, Ontario.

LIBRARIAN—Registered record; for new 300-bed hospital; full charge in setting up new installation; located 30 minutes from New York City. Write stating education and experience. MO 170, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

MISCELLANEOUS—Wanted Biochemist, also Laboratory Technologist; 250-bed hospital; salaries open. Apply MO 171, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

MISCELLANEOUS — Science instructor to teach the basic biological and physical sciences in a fully accredited school of nursing, 170 students, 350-bed hospital in large metropolitan city with educational and cultural advantages; college affiliation; living in quarters available; personnel policies excellent; position open also for INSTRUCTOR in OBSTETRIC NURSING; salary open in both positions. Apply MO 175, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

MISCELLANEOUS—Director of Nurses; experienced, no degree necessary; no school, 140-bed approved hospital; social security and hospital retirement plan; private apartment available; attractive salary; population over 65,000. Also wanted, Night Supervisor; 15-bed Pediatric Head Nurse. Apply Administrator, Fort Hamilton Hospital, Hamilton, Ohio.

MISCELLANEOUS—Eligible for Virginia registration: needed-6 openings, 7-3; nursing office supervisor; 3-11 nursing office supervisor; 11-7 nursing office supervisor; operating room nurse; two general duty nurses; good salaries, quarters provided. Apply Director of Nurses, Martinsville General Hospital, Inc., Martinsville, Virginia.

(Continued on page 180)

NURSES—starting salary $344; $360 after six months; modern 450-bed county hospital; 3 weeks vacation, sick leave, retirement. Apply Contra Costa County Civil Service, Box 710, Martinez, Calif.

NURSES—Male; all shifts; $330.00 evenings; $320.00 nights; $310.00 days; liberal benefits. Apply St. Anthony's Hospital, 2875 W. 19th, Chicago, Illinois.

NURSES—General duty, operating room and delivery room; salary $315.00 to $351.00 per month plus department premium of $10.00; shift premium $20.00 extra per month; vacation up to 4 weeks; retirement program, and social security; hospitalization insurance, 40 hour week; hospital located on university campus. Apply Director of Nursing, Palo Alto Hospital, Palo Alto, California.

NURSES—General duty for 306-bed general hospital; serving community of 100,000; starting salary $275 per month plus meals and laundry; bonus of $25 for evening and night shifts; increment of $5.00 every six months for a period of four years; hospital twenty miles from New York City on Long Island Sound; train service every half hour. Apply Director of Nursing, New Rochelle Hospital, New Rochelle, New York.

NURSE—General duty; for 17-bed hospital; starting salary $200 gross; 1 month vacation with pay after 1 year service, $5.00 per month increase after each 6 month service up to 3 increases; transportation refunded after 6 month service. Apply Municipal Hospital, Elnora, Alberta.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature, experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSE—Operating room; for modern air-conditioned, two room suite, in 52-bed general hospital; 12 days sick leave, 2 weeks vacation annually, paid holidays, annual bonus, 40-hour week; salary open. Apply Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

NURSES—Registered; for modern psychiatric hospital in Greens Farms, Connecticut; 1 hour from New York; Hall-Brooke nurses have 8-hour duty, optional 5 or 6 day week, nicely furnished private rooms; excellent salary, 7 paid holidays annually, or equivalent; sick leave; vacation, minimum 2 weeks, maximum 4 weeks dependent on length of service; profit-sharing plan; psychiatric experience not necessary; registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Directress of Nursing, Hall-Brooke, Box 31, Greens Farms, Connecticut. Tel. Westport—Capital 7-5105.

NURSE — Registered; interested in teaching practical nursing; opportunities to develop own program; school not approved at present; desire individual capable of developing program which will meet State approval; small town located in southeast Pennsylvania. Apply MO 144, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Registered; for a 50-bed general hospital; 40 hour week, two weeks vacation, two weeks sick leave, six paid holidays paid Blue Cross-Blue Shield; room and board in pleasant nurses home; salary range $303 to $355 per month; increases every six months for two years; shift differential for evening and night work. Apply Illini Community Hospital, Pittsfield, Illinois.

NURSES — Registered; immediate openings; starting salary $240 month with opportunity for advancement; room, board and laundry annual vacation, liberal sick leave, 40 hour, 5 day week. Apply Personnel Office, Mental Health Institute, Independence, Iowa.

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**A paper delivered by John L. Mayer, Jr., at an A.A.H.A. conference, Orlando, Florida*

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POSITIONS OPEN

NURSES—Registered: Massachusetts General Hospital, Boston, Massachusetts; excellent clinical facilities, opportunity for advancement and attendance at local colleges; liberal personnel policies. Apply Personnel Department A-10 for further details.

NURSES—Registered; 83-bed hospital comprised of 43-bed general hospital and 40-bed retired miners; starting pay $300 per month with periodical increases; nurses home reasonable charge for board and room; 40-hour week. $15 differential pay for evening shifts, liberal personnel policies; town of 9000 in the mountains. Apply Miners' Hospital, Raton, N.M.

NURSES—Registered: are you looking for something new? Staff and assistant head Nurse positions open in beautiful new University of Oregon Medical School Hospital located on hill overlooking Portland, Oregon; medical surgical, pediatric and psychiatric units; excellent opportunities for learning, both in clinical areas and on campus; staff members may take courses at reduced tuition rate ($3 per quarter hour) leading to baccalaureate or masters degrees at the nursing school on the campus; liberal personnel policies; the northwest is a wonderful place to live and work. Write to Director of Nursing Service for full information. U. of O. Medical School Hospital, 3181 S. W. Sam Jackson Park Road, Portland 1, Oregon.

NURSES—Registered; needed for a 500-bed Veterans Administration Hospital; basic starting salary $4025 per year with yearly increase to $4885; higher salaries based upon experience and educational qualifications. 30 days annual leave, 15 days sick leave, 8 holidays per year. 40 hour week; current registration as a graduate nurse in any State. Write Chief, Nursing Service, Veterans Administration Hospital. Dallas, Texas.

NURSES—Registered; for general duty for 150-bed tuberculosis sanatorium in Bartlett, Alaska; starting salary $353 per month with a $10 raise each six months to a maximum base pay of $383; $10 extra for evening and night shift; 8 hour day, 40 hour week, 8 to 4, 4 to 12, 12 to 8 shifts; complete maintenance available for nominal sum; new modern nurses residence; also opening for night supervisor. Write to Director of Nurses, Seward Sanatorium, Bartlett, Alaska.

NURSES—Registered general duty; required at McKellar General Hospital, Fort William, Ontario; good personnel policies; residence accommodation available at reasonable rates hospital has recently completely a well equipped and staffed wing with extensive renovation program progressing in the old section. Apply Director of Nursing.

NURSES—Staff; for 300-bed general hospital; attractive personnel policies, plus differential for specialties, afternoon and night duty; opportunities for advanced education. Apply to Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

NURSES—Staff; for new expanding hospital on Florida's west coast; salaries and personnel policies compare favorably with those in this area; 40-hour week, 4 weeks vacation, no shift rotation; Florida registration required. Apply Supervisor Nursing Service, Manatee Memorial Hospital, Brandenton, Florida.

SUPERVISOR—Operating room; 200-bed general hospital; experienced; 40 hour week, salary open. Apply Director of Nursing, Iowa Lutheran Hospital, Des Moines, Iowa.

NURSES—Supervisory and staff; 50-bed, well equipped modern hospital; basic salaries, general staff, $270; supervisory $300; 40 hour week, differential for nights, call, special training or experience; located in Hiway 99 halfway Seattle and Vancouver, B.C.; scenic, sports, fishing and hunting. Apply Administrator, Memorial Hospital, Sedro Woolley, Washington.

SUPERVISOR—Operating room; 115-bed fully accredited general hospital in Buffalo-Niagara Falls area; salary commensurate with experience and qualifications; living accommodations available. Write Director DeGraff Memorial Hospital, North Tonawanda, New York.

SUPERVISOR—Operating room; for 553-bed hospital; newly built and equipped operating rooms; opened November 1956; active surgical schedule—approximately 40 procedures daily; student nurses rotated through O.R.; operating room technician program; attractive personnel policies; very pleasant working conditions; B.S. degree and experience required. Apply to the Director of Nurses, Western Pennsylvania Hospital, Pittsburgh 24, Pennsylvania.

TECHNOLOGISTS—Laboratory; 350-bed general hospital adjacent to University of Kentucky, in Lexington, "The Heart of the Bluegrass"; salary $250-$350, 40 hour week, vacation, sick leave, laundry, meals on duty, holidays, etc. Write Assistant Administrator, Good Samaritan Hospital, South Limestone Street, Lexington, Kentucky.

TECHNOLOGIST—Medical registered 160-bed general hospital, college town, 20 miles west of Milwaukee, major expansion program including new department of laboratory medicine to be started in spring of 1957; affiliation with Carroll College for training of medical technologists now in development stage; full time pathologist. Apply Personnel Department, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

TECHNICIAN—Laboratory; 150-bed general hospital; employ three full time and three part time technicians; salary open, full maintenance, attractive living conditions. Apply MO 174, The Modern Hospital, 919 N. Michgan Avenue, Chicago 11, Illinois.

TECHNICIAN—Laboratory; easy department; or combined laboratory and x-ray technician; particulars on request. Apply St. Ann's Hospital, Juneau, Alaska.

ADMINISTRATORS—(aa) Fully approved 300-bed voluntary general hospital; teaching program; excellent board and staff; midwest (a) Medical; 300-bed sanitarium; $12,000; if qualified also serve as county physician $15,000; California. (b) New 100-bed clinic hospital; planning nurses' school; large university city; southwest. (c) General hospital, 125-beds, fairly new; San Francisco area. (d) 240-bed JCAH teaching hospital; excellent medical staff; expanding; town 125,000; mideast. (e) Must have had good experience; 75-bed hospital, building prorgam; New York State. (f) Business manager, 200-bed hospital; town 37,000, California; to $6300. (g) Need 2; supervise plans for construction and licensing of hospitals; midwest.

(Continued on page 182)

WOODWARD—*Continued*

ADMINISTRATORS—WOMEN: (a) R.N. or non-medical; fairly new 50-bed general hospital; to $7,000; popular resort area; mideast. (b) Voluntary general hospital now under construction, to be completed mid-1957; 40-bed facility; residential community, California. (c) R.N.; newly opened geriatric convalescent facility, 60-beds; $5000 up; college city 600,-000; east. (d) R.N. or non-medical; 25-bed Hill-Burton facility to be completed April 1957; small community serving drawing area 10,000; northwest.

ASSISTANT ADMINISTRATORS—(gg) One with several years hospital construction experience, business degree, including systems, purchasing; $8000; more if experience warrants; 350-bed, JCAH, voluntary general; east. (h) New general 275-bed hospital; delightful climate; near San Francisco. (i) Only general voluntary hospital in county; 100-beds; expansion program; east. (j) General hospital, large size; $10,000 up; Caribbean seaport; Central America. (k) Children's hospital, very large size; opportunity assume directorship, several years; university city. (l) Prefer under 30; consider older; hospital 100-beds increasing 50-beds; large university city, midwest; (m) 225-bed general hospital; teaching program; attractive town 60,000 on ocean; West coast. (n) MHA degree; 120-bed modern hospital; near Chicago. (o) With purchasing, public relations experience; fully approved, 300-bed general, voluntary hospital; attractive university city near fine hunting, fishing; in summer-winter resort area; warm, year round climate; Pacific Northwest; $7000-$7500.

ADMINISTRATIVE ASSISTANTS—(o) 30-35 of age; must be qualified in accounting; small hospital, laboratory and x-ray facilities; town 63,000, California. (p) Two general hospitals, large size; town 200,000; west-north-central area; attractive offer. (q) One interested in fellowship, ACHA; must be graduate, accredited school of hospital administration; prefer two years experience; to assume responsibility for administrator; 375-bed State mental hospital; $8,200, 1st years, then increases; midwest. (r) 80-bed, voluntary hospital; requires young man with degree in hospital administration; good opportunity for advancement; California.

ANESTHETISTS—(a) Voluntary general hospital 150-beds; $5400, room; city 55,000; west. (b) Staff of 3 in excellently equipped department, 160-bed general hospital; to $5500; resort, college community; midwest. (c) Air-conditioned, well equipped surgery suite, small general hospital, has active surgical service; $6000; southern community 15,000. (d) Small industrial hospital 40-beds; average 35 procedures per month; $5400; small town, Far West.

DIETITIANS—(a) Full responsibility for department, voluntary general hospital 125-beds; college town, northwest. (b) Chief; full charge, dietary service, very large state psychiatric hospital; to $5800; attractive town 25,000; midwest. (c) Chief; new, fully equipped department, centralized tray service; 250-bed general hospital; small town near university center; east.

DIRECTOR OF NURSES—(a) Nursing service and affiliate student program, pediatric nursing; 70-bed pediatric hospital, approved; lovely city, university center; south. (b) Nursing service and education; degree, experience as assistant in large hospital necessary; collegiate affiliated school, 150-bed general hospital, expanding soon; to $7200; trade center, scenic area; southwest. (c) Nursing service and education; approved 175-bed general hospital; lovely resort, college

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Warm and friendly wood hospital furniture by THONET brings a reassuring suggestion of home into the hospital room. Functional and contemporary in styling . . . engineered to meet the requirements of efficient hospital operation, this 800 group is available as a complete room, or as single pieces to meet your every space requirement.

#1006 High back chair

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#803 Bed

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#824 Bedside-Chest

#833 Dresser Desk

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POSITIONS OPEN

WOODWARD—*Continued*

community; mideast. (d) Nursing service and education; 200-bed private neuropsychiatric hospital; now constructing all new general hospital; important midwestern university center.

EDUCATIONAL DIRECTORS—(a) Collegiate affiliated school, 75 students; temporary national accreditation; approved 200-bed general hospital; to $5000; cosmopolitan city 25,000; midwest. (b) Associate; 3-year course, 90 students; 300-bed general hospital; $4200; eastern resort area. (c) Nearly 100 enrolled in approved school; general hospital 200-beds; city 50,000; south.

EXECUTIVE HOUSEKEEPERS—(a) Supervise 75-100 employees; very large university affiliated general hospital; to $6000; midwest. (b) Fully approved voluntary general hospital 300-beds; progressive, scenically located city, Pacific Northwest. (c) Staff of 50 in department, 500-bed university affiliated hospital; industrial, university city; east.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 NORTH MICHIGAN AVENUE CHICAGO

ADMINISTRATORS—(a) Medical superintendent; major teaching hospital of state university; 1000-beds; (b) Assistant medical administrator; hospital group; would direct 400-bed unit on his own; midwest. (c) Executive director; voluntary general hospital; upon completion new addition will have 500-beds; three assistant directors; university city, midwest. (d) To succeed administrator resigning after 15 years; general hospital, 140-beds; plans completed for expansion program to 260; suburb, university city, east. (e) Consultant; state health department division of hospitals; $7000-$8000. (f) Administrator; 375-bed general hospital; medical center; midsouth. (g) New 50-bed general hospital now nearing completion; should be qualified undertake full responsibility; $8000-$10,000; California. (h) Assistant; Master's degree, minimum 2 years' experience required; 300-bed general hospital, JCAH; foreign operations, large company; $9300 (Federal tax free), family maintenance, travel expenses. (i) Assistant; 350-bed university hospital; $7500-$8000; east. (j) Assistant; 300-bed general hospital; California; $6000. (k) Assistant; preferably one qualified purchasing, public relations; 275-bed general hospital; Pacific Northtwest. (l) Clinic manager; 20-man group; university city, midwest. MH2-1

ANESTHETISTS—(a) Small research clinic; no call duty; San Francisco Bay area; start $5200. (b) Take complete charge surgery; 45-bed hospital; best equipment; Wisconsin ski, fishing country; $5000 plus fee percentage. (c) Two, no obstetrics; eight modern surgical suites; 250-beds; state capital; university center, midwest; to $6600. (d) Head department, 40-bed hospital; centrally located winter-summer resort; ideal situation; Florida; top salary. MH2-2

DIETITIANS—(a) Director of Food Services; coed college; Illinois; to 7200. (b) Chief; 400-bed hospital; midwest medical center; all modern equipment; department of 80; $7000. MH2-3

DIRECTORS OF NURSING—(a) Nurse consultant; national health, welfare organization; Connecticut; top salary for right person. (b) Complete responsibility for nursing service, renowned university hospital, 1000-beds; must be administrator of highest caliber; faculty appointment; salary commensurate ability. (c) Director service, education; 350-bed general hospital, 200 students; deep south; $6000 up, maintenance. (d) Assistant director

(Continued on page 184)

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

ready to assume responsibility as director of school, service; 150-bed hospital with expansion program to 250; Texas oil center; to $7200. MH2-4

EXECUTIVE HOUSEKEEPER—200-bed hospital, near New York City; congenial staff; department of 25; good financial opportunity. MH2-5

EXECUTIVE PERSONNEL—(a) Business manager; voluntary general hospital, 200-beds; attractive college town, California. (b) Controller and office (25 personnel) manager: 400-bed general hospital; minimum, $7000; east. (c) Engineer, civil or mechanical; hospital experience; state health department: $7000-$8000. (d) Director of personnel and public relations and, also, purchasing director; general 250-bed hospital increasing to 450; town 75,000, lake resort area, near university center, midwest. (e) Accountant; 350-bed general hospital; California. (f) Personnel director; 600-bed general hospital; vicinity New York City. (f) Food service manager; university medical center; new modern hospital, 350-beds; $6500; southwest. MH2-6

MEDICAL BUREAU—*Continued*

FACULTY POSTS—(a) Instructor office nurse technique; small coed college; midwest; $550 month. (b) Assistant professor pediatrics, renowned university department of nursing; near New York City; $500 month; also medical, surgical. (c) Director of education, noted progressive 400-bed hospital outside United States; English speaking faculty, 180 students; to $6600. (d) Psychiatric institute, newly organized collegiate school; lake campus; metropolitan area; leading midwestern city; to $560 month. MH2-7

RECORD LIBRARIANS—(a) Medical, prominent research group; extremely responsible position; salary commensurate ability, New York City. (b) Consultant; oversee well organized departments of two hospitals, 200, 65-beds; college town, summer resort Upper Michigan; $5000 up. MH2-8

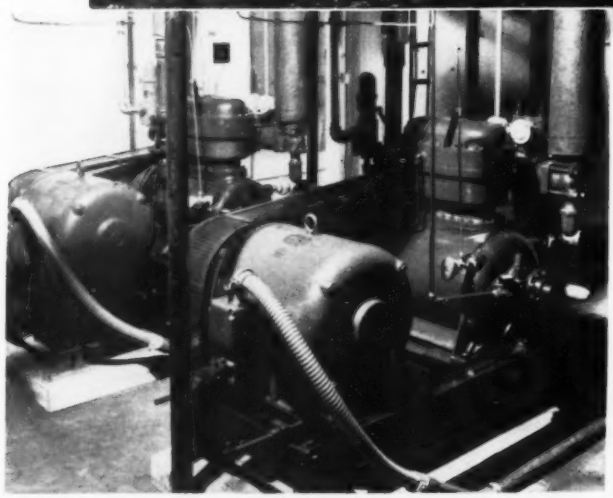
SUPERVISORS—(a) Pediatric; 350-bed fully approved hospital; progressive administration; leading industrial city, near lake resort, Michigan; $5000. (b) Nurse supervisor to manage Rest Home, 40 patients; wealthy Chicago suburb; salary, maintenance, plus annual bonus. (c) Operating room; 350-bed hospital exclusive residential area outside New York City; $5000 up. (d) Obstetrics; 150-bed hospital no teaching; busy department, modern equipment; Florida. MH2-9

(Continued on page 186)

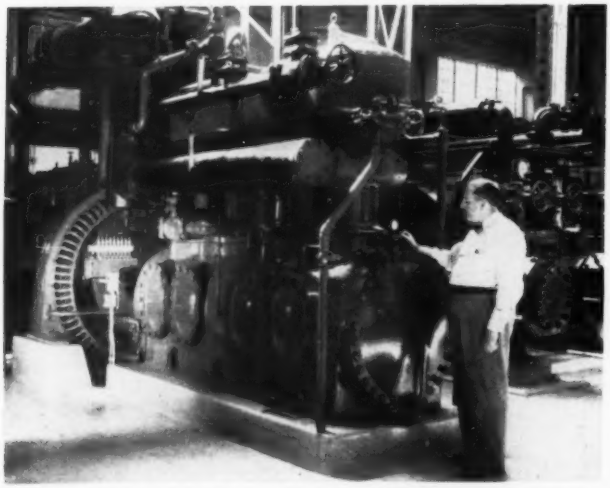
SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

EXECUTIVE PERSONNEL—(a) Personnel and public relations director; middle west; 200-bed hospital expanding to about 450-beds; excellent opportunity for qualified person; top salary. (b) Administrative assistant; woman; supervise institutional services of two 250-bed hospitals; to $7200. (c) Personnel relations officer; southwest; 350-bed hospital, affiliated with university; 650 employes. (d) Comptroller; east; 125-bed hospital, affiliated with university; $500 minimum. (e) Business manager; Florida. 50-bed hospital; good accounting training; $500. (f) Personnel director; middle west; 350-bed hospital; require experience as assistant personnel director in either hospital or industry. (g) Assistant director; large hospital in the east; college degree preferably in business administration; to $8000.

MEDICAL RECORD LIBRARIANS—(a) Chief; south; 350-bed hospital in city of about 100,000; nine employes in department. (b) Chief; east, 400-bed hospital; nine in department; installed new Kardex system last year. (c) Chief; south; large teaching hospital $5000. (d) California; 350-bed hospital in city of 40,000; $5000. (e) Chief; middle west;



Some of the Frick "ECLIPSE" Compressors at Hotel Hershey.



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POSITIONS OPEN

SHAY—*Continued*

350-bed hospital in college town; 14 employes in record room; $6000. (f) Chief; east; staff of six in record room; 250-bed hospital; $5100. (g) Chief; Florida; 150-bed hospital; 2 registered librarians and 4 clerks in department; $4800.

CLINICAL CHEMIST—(a) East; 425-bed hospital; have just completed a new pathological laboratory; excellent opportunity; $7000-$10,000. (b) Bio Chemist; east; large hospital; pathology laboratory well equipped and well staffed; require Ph.D.; $10,000.

NURSE ANESTHETISTS—(a) Northwest; 200-bed hospital; 2 nurse anesthetists and one anesthesiologist in department; $500. (b) Florida; 200-bed hospital; 5 in department; $500. (c) South; new 80-bed hospital in college town; $500. (d) Middlewest; 120-bed hospital; 3 in department; will consider woman or man; $500. (e) South; man or woman; 5 in department; plus 4 anesthesiologists on staff; 250-bed hospital; $550. (f) Southwest; 50-bed hospital; good personnel policies; $600.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Day, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—(a) 300-bed hospital, Michigan. (b) 375-bed hospital, Ohio; M.H.A. Degree required. (c) 275-bed hospital, western city. (d) 60-bed hospital, northwest. (e) 40-bed hospitals, Ohio, California, Pennsylvania, Virginia.

SUPERINTENDENT—(a) 30-bed hospital, Ohio; expansion program. (b) Home for Aged. $400, maintenance. (c) Tuberculosis and chronic hospital, west.

BUSINESS MANAGER—(a) 200-bed hospital, California. (b) 385-bed Ohio hospital. (c) New hospital, 135-beds, Ohio. (d) 175-bed eastern hospital; $6500.

ASSISTANT ADMINISTRATOR—(a) 400-bed hospital, New England. (b) Personnel directors; to $500.

DIRECTOR, NURSING SERVICE—(a) West Coast; new building planned; $7,000. (b) 275-bed Ohio hospital; $600, maintenance. (c) Michigan; $550.

INTERSTATE—*Continued*

BACTERIOLOGISTS—(a) Ohio, Michigan hospitals; $6500. (b) Laboratory technicians; $400, east. (c) Chief x-ray technician, Pennsylvania. (d) Laboratory and x-ray technicians, midwest, southwest; $375.

CHIEF DIETITIAN—(a) 375-bed hospital, Ohio; industrial city; $6000. (b) Therapeutic; to $400.

PHARMACIST—(a) 300-bed Ohio hospital; $6,000.

EXECUTIVE HOUSEKEEPERS—(a) 350-bed southern hospital. (b) 300-bed hospital, New York State. (c) 150-bed hospital, Ohio. (d) 200-bed hospital, east. (e) 400-bed hospital, Florida.

MEDICAL EMPLOYMENT SERVICE

59 East Madison Chicago 2, Ill.
ANdover 3-5663-64
Alfred E. Riley, R.N., MSHA Director
Dorothea Bowlby, Counselor

ADMINISTRATORS—(a) 350-bed fully approved hospital; excellent opportunity, $20,000 to $25,000; midwest. (b) 400-bed hospital; midwest; $18,000. (c) Small general hospital; New England; $8,000. (d) Hospital consultant; 3000-bed hospital (6 months)

(Continued on page 188)

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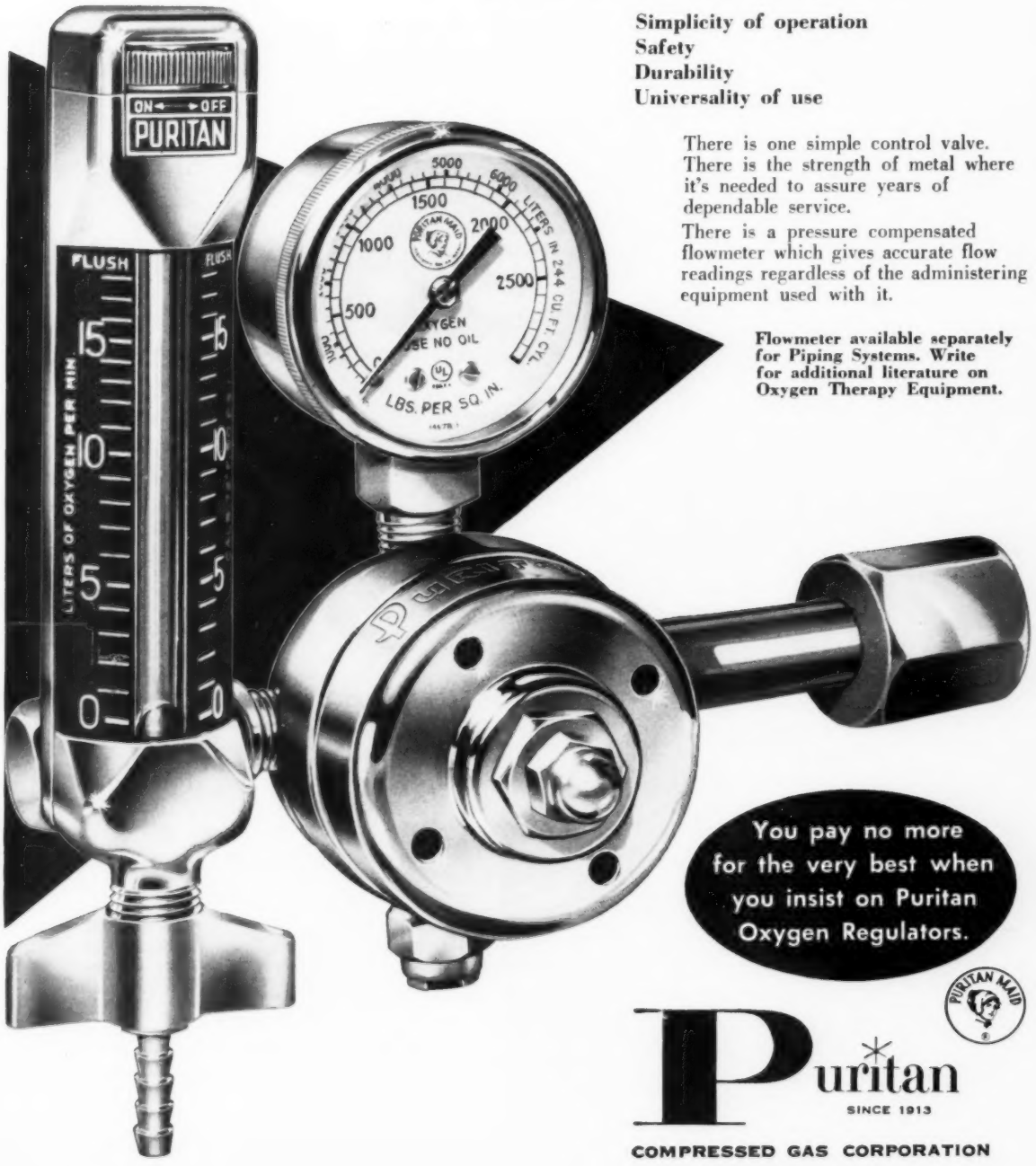
Of the many things that can be said about an Oxygen Regulator—here are the points that really count:

Simplicity of operation
Safety
Durability
Universality of use

There is one simple control valve. There is the strength of metal where it's needed to assure years of dependable service.

There is a pressure compensated flowmeter which gives accurate flow readings regardless of the administering equipment used with it.

Flowmeter available separately for Piping Systems. Write for additional literature on Oxygen Therapy Equipment.



You pay no more for the very best when you insist on Puritan Oxygen Regulators.

Puritan
SINCE 1913

COMPRESSED GAS CORPORATION
KANSAS CITY 8, MO.

PRODUCERS OF MEDICAL GASES AND GAS THERAPY EQUIPMENT

classified advertising

MEDICAL EMPLOYMENT—*Continued*

recent graduate MHA; $8,000. (e) Voluntary general hospital, small summer resort town. (f) 80-bed hospital; midwest; $10,000. (g) 225-bed hospital; west coast; $16,000. (h) 100-bed hospital; east coast; $9,600. (i) 150-bed new hospital; Texas. (j) 145-bed hospital new; midwest; $12,000. (k) 100-bed hospital; university town, south; $8,000 to $9,800.

ASSISTANT ADMINISTRATORS—(a) 400-bed hospital; midwest; $8,000. (b) 400-bed Baptist hospital; south; recent MHA graduate; $7,200. (c) 250-bed hospital; California; $8,000 to $10,000. (d) 300-bed general hospital; Texas.

DIETITIAN—(a) Consultant, 4 hospitals; car furnished, travel expenses, excellent salary. (b) Teaching hospital, university affiliation; to $7,200. (c) Chief; south; $6,000. (d) Chief; midwest; $6,500. (e) Chief; midwest; R.R. hospital; $5,400.

DIRECTOR OF NURSING—(a) Large midwest teaching hospital; 500-beds; salary $10,000. (b) 200-bed hospital; small school near large industrial city; $6,500 to $8,000. (d) Large teaching hospital; south.

MEDICAL RECORD LIBRARIANS—(a) Chief, large general hospital. (b) Chief; new hospital 100-beds. (c) Chief; well organized department; Florida. (d) 500-bed teaching hospital; south. (e) University teaching hospital; new department; midwest.

PLACEMENT BUREAUS

MARY A. JOHNSON ASSOCIATES

11 West 42 Street New York 36, N. Y.

Mary A. Johnson, Ph.D., Director

FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven methods shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee

Agency

(Continued on page 190)

HOSPITAL PERSONNEL BUREAU

Knickerbocker Bldg. 218 E. Lexington St.
Baltimore 2, Maryland
"LExington 9-5029"
Chas. J. Cotter, Director
(Former Administrator)

Nation-wide placement service for Physicians, Administrators, Anesthetists, Dietitians, Nurses, Technicians, Pharmacists, Comptrollers, Accountants, Secretary, Housekeepers, etc.

Mail resume, 5 photos, salary.

No Registration Fee. Licensed Employment Agent.

(formerly Hagerstown, Maryland)

Information about

QUALIFIED NURSE PERSONNEL

is available from the

American Nurses' Association

PROFESSIONAL COUNSELING & PLACEMENT SERVICE

37 So. Wabash Ave.
Chicago 3, Ill.
STate 2-8883

classified advertising

PLACEMENT BUREAUS

PROFESSIONAL MEDICAL BUREAU
Division of
Professional Nurses Bureau

6087 Sunset Blvd. Los Angeles 28, Calif.
John Patterson, Director

Marcella O'Sullivan, Assistant Director

We are pleased to provide confidential service to applicants and employers in the hospital, medical and allied fields. We welcome all inquiries regarding available positions or our well qualified candidates.

A bonded and licensed professional agency.

PROFESSIONAL PLACEMENTS
Agency
432 North Lemon Avenue
Ontario, California

A. G. Turner R. T. McHugh

Free counseling service to those interested in medical placements in the Western states. Listings and inquiries are confidential.

No registration fees.

Licensed by the State of California

INDIANA MEDICAL BUREAU

212 Bankers Trust Bldg.

Indianapolis, Indiana

Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

FOR SALE

NURSING AND MEDICAL BOOKS

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS
400 East 59th Street, New York City

(Continued on page 192)

MISCELLANEOUS

HOSPITAL PERSONNEL
Nurse Anesthetists
Registered Nurses
Medical Technologist

Excellent benefits including forty-hour week, four weeks vacation annually, assured annual salary increase, shift differential, non-contributory retirement plan and medical coverage.

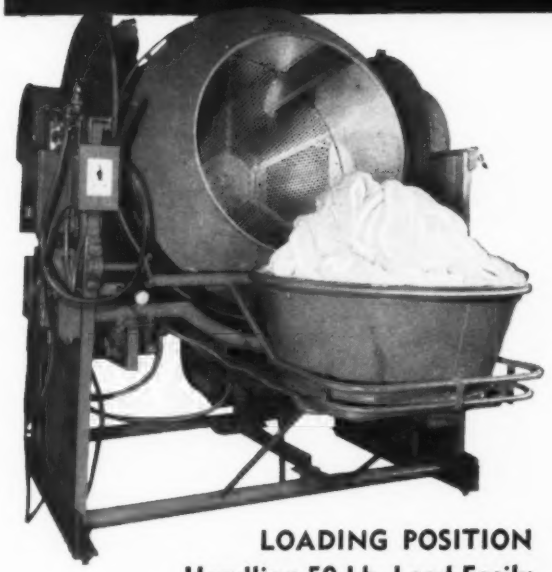
Salaries vary due to degree of qualifications. Nurse Anesthetists $5880.00 to $7080.00; Registered Nurses $4440.00 to $6420.00; Medical Technologist $4020.00 to $5880.00.

Here is your chance to answer a challenge and to grow with it.

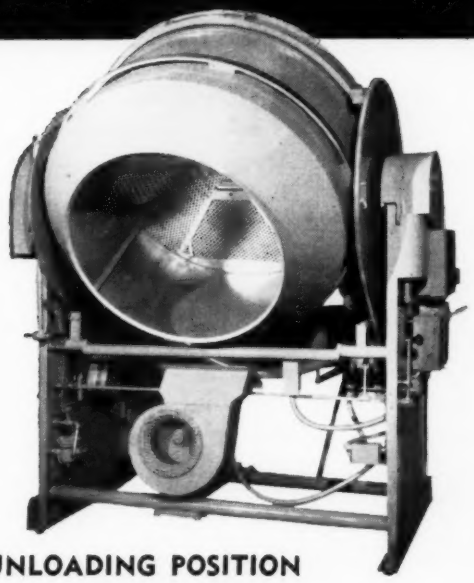
For full details just send your name and address to Miners Memorial Hospital Association, Box No. 61, 110 Logan Street Williamson, West Virginia.

WANTED
Used X-ray films, all sizes. Please contact:
Minerva Commercial Corporation
315 Fifth Avenue
New York 16, New York

You'll say *"It's amazing... even unbelievable"*... when you see how the new Purkett 48" "Pre-Dryer" conditions flat work and garments



LOADING POSITION
Handling 50 Lb. Load Easily



UNLOADING POSITION
Shows Powerful Blower

Especially for the 1-ironer plant where formerly only the 72" size was available with Pre-Drying

Affectionately called "BIGMOUTH" this equipment . . .

1. Will keep your ironers working full capacity with improved quality throughout.
2. Removes one gallon additional moisture in 5 minutes tumbling time.
3. Eliminates re-runs by removing excessive moisture and keeping remainder properly distributed.
4. Increases production with less labor by eliminating costly hand shake-out . . . employee fatigue reduced.
5. Pays for investment in 12-18 months.

These and more advantages described in the new file folder on the 48" "BIGMOUTH" . . . It's yours for the asking.

PURKETT'S CONSULTING SERVICE . . . A Purkett specialized engineer will consult with you on your linen and garment conditioning problems . . . without obligation to you.

Naturally it's a PURKETT

Purkett equipment is sold by ALL Major Laundry Machinery Manufacturers and by

PURKETT MANUFACTURING COMPANY

Joplin, Missouri

DEPENDABLE PRE-DRYING CONDITIONING TUMBLERS

classified advertising

SCHOOLS—SPECIAL INSTRUCTION

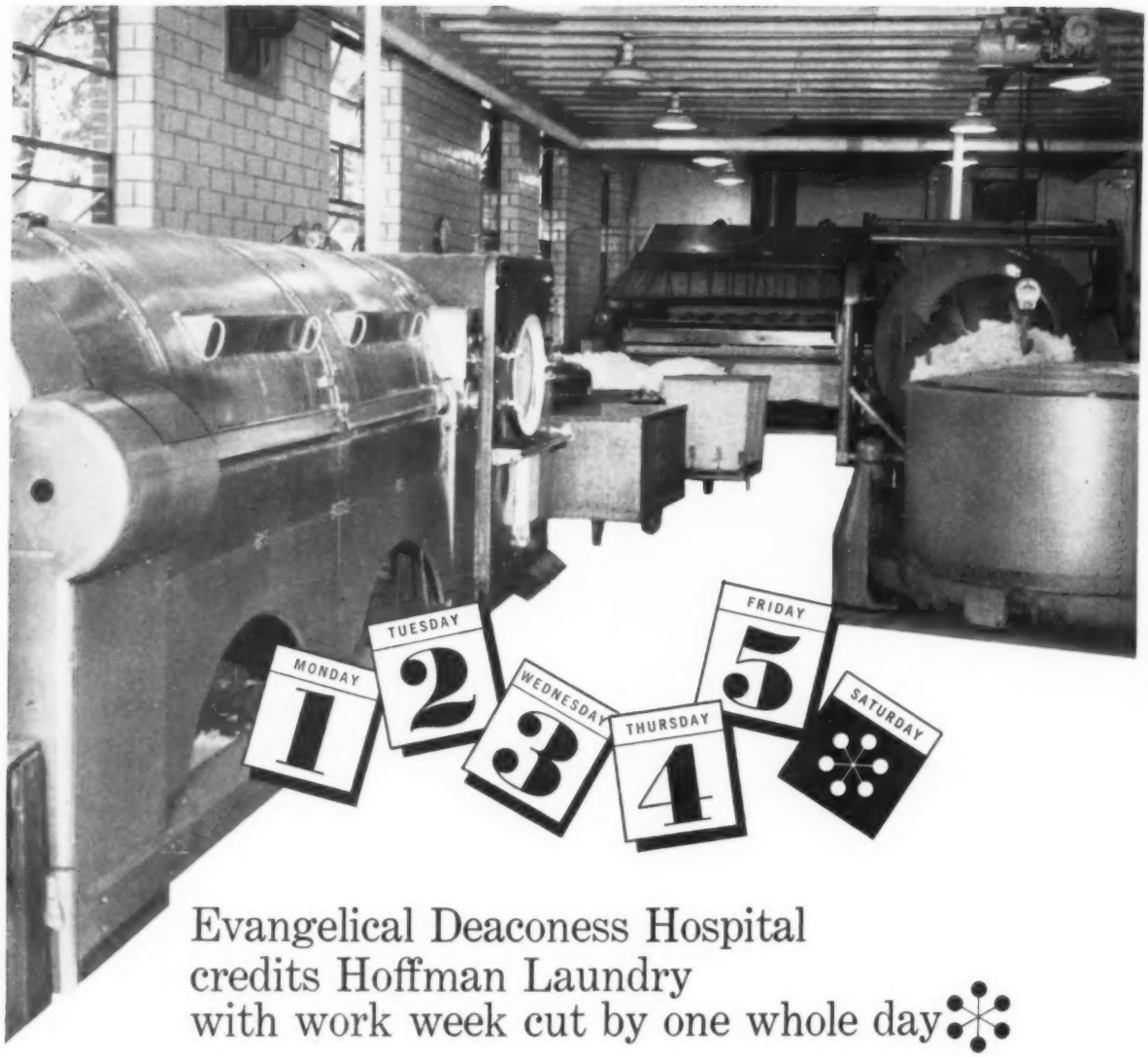
The BOSTON LYING-IN HOSPITAL offers to qualified registered nurses a six-months internship in maternity nursing. Clinical experience is offered in all phases. This includes antepartal clinics, delivery room, postpartum and diabetic unit, normal newborn, and premature nursery. Each nurse intern will have the opportunity to deliver a mother under supervision. An elective period will be spent in advanced experience in the area of choice. Room, laundry, food allowance and a stipend of $75 per month is granted. Rooms are provided in a graduate house. The registration fee is $20. For complete information write to Carolyn Davies R.N., Director of Nurses, Boston Lying-in Hospital, Boston, Massachusetts.

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in OBSTETRIC NURSING to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA offers a four month course in operating room technic and management to registered graduates of accredited schools of nursing. Registration fee $20.00. Full maintenance and $30.00 monthly cash allowance given. Apply to Director of Nursing Service, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.



Evangelical Deaconess Hospital credits Hoffman Laundry with work week cut by one whole day

In the four years since installation of their Hoffman laundry the Evangelical Deaconess Hospital of Cleveland, Ohio, has experienced the following savings:—

Direct labor costs, 40% reduction; supply costs, 75% reduction; linen replacement, 42% reduction; laundry employees reduced from 12 to 10; 8-hour days worked per week cut from six to five. At the same time, the weekly poundage laundered was increased by 10%!

And this is how it was done! Increased drying and ironing facilities eliminated the bottleneck of wet work from washers. Mechanized loading and unloading of the extractor by hoist-handling and an increased rate of extraction gave a faster steady output, using the same manpower. Organization of the work-flow and speedier processing avoided shortages in the distribution of linen.

"The testimony of users of Hoffman equipment," says an official of the Evangelical Deaconess Hospital, "and the generous engineering service rendered by the field representative of U.S. Hoffman Machinery Corporation, contributed heavily in our decision to select Hoffman equipment."

Hoffman will be happy to help you, too, to determine your specific needs, and to enjoy the lower operating costs and exceptional efficiency of a Hoffman institutional laundry. Your copy of our bulletin on institutional laundry equipment is available now on request to:—

INSTITUTIONAL LAUNDRY DIVISION

U.S.HOFFMAN MACHINERY CORPORATION

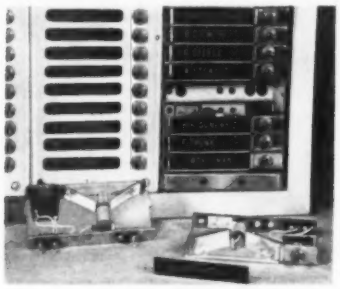
105 FOURTH AVENUE, NEW YORK 3, N. Y.

Laundry consists of: 350-pound unloading washer • 100-pound open-end washer • 30-inch extractor • 6-roll flatwork ironer • Shake-out tumbler • 54-inch unloading extractor • 225-pound unloading washer (not shown)

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 224. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

In-and-Out Register Features Modular Construction

Flexibility of installation due to the modular construction is a special feature



of the new Couch Staff In-and-Out Register. Registers are available in three types, each consisting of a group of name tiles upon which are engraved the names of staff members, with lights and frame. Name tiles, with their associated lamps, are individual plug-in units and can be quickly withdrawn for re-lamping or changing of name. Lamps with a life of 3000 hours are used in the register for long service between replacements. Lamps, name tiles and switches are immediately available upon removal of the cover plate secured by four screws.

The new registers are small in size, each name occupying a vertical space of only $\frac{11}{16}$ of an inch but containing sufficient space for sixteen characters. A given number of names can be arranged in a variety of ways in the registers, either within the frame or by the use of more than one frame if required. Standard registers are available to accommodate from ten to 400 names. **S. H. Couch Co., 3 Arlington St., North Quincy 71, Mass.**

For more details circle #161 on mailing card.

Ophthalmic Surgical Light Has Special Lens

A special lens designed to trap all distracting side glare when the light is brought down in close proximity to the surgeon is the feature of the new Castle Ophthalmic Surgical light. The lamp is designed to have a particular application to large-area eye surgery. The cover glass is the result of years of research by Corning Glass and is cross-hatched with a grill of 14 inch louvers which are actually imbedded in the glass itself. Horizontal light spillage is thus controlled, causing virtually all of the beams to be directed straight downward. Available floor-mounted or as a single or double-headed ceiling fixture, each lamp is equipped with an adjustable focusing device. The lamp gives heat-filtered, glareless, color-corrected illumination in a concentrated four-inch spot or a wide, soft 12-inch field. **Wilmot Castle Co., 1876 E. Henrietta Rd., Rochester 18, N.Y.**

For more details circle #162 on mailing card.

Medical Utility Glove Now Made in Yellow

A color change is announced for the Pioneer U-35 Medical Utility Glove. Now offered in yellow, the neoprene glove, which is resistant to oil, grease and disinfectants, has a suede-like yellow flock lining for comfort of the user. The U-35 retains the curved, fitted fingers, roomy palm and knuckles and non-

slip grip of the earlier model and is designed for use in hospital housekeeping, autopsy and general non-surgical procedures. **Pioneer Rubber Co., 396 Tiffin Rd., Willard, Ohio.**

For more details circle #163 on mailing card.

Flameproof Curtains Are Washable

Hill-Rom Flameproof Curtains for patient room cubicles are processed with a chemical application which permits them to be laundered repeatedly without loss of their flameproof qualities. The material used is Hill-Rom Cordette which is immersed in a chemical compound for a period of time to permit the chemicals to become a part of the yarn. The fabric is then dyed and put through another chemical to set the chemicals in their proper proportions. The resulting cotton fabric will not support flame and in the presence of intense fire only chars. The curtains are available in Cream, Peach and Green shades. **Hill-Rom Co., Inc., Batesville, Ind.**

For more details circle #164 on mailing card.

(Continued on page 196)

Curity Adhesive Stays Fresh

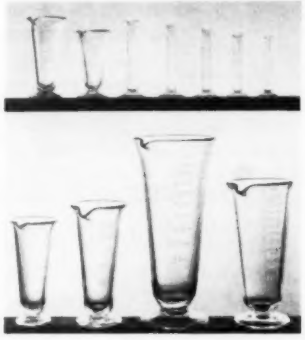
Improvements in Curity Adhesive Tape are designed to fulfill exacting hospital requirements for a surgical tape. They are the result of more than four years of research and development. Improved Curity Adhesive stays fresh, unwinds easily and can be used to the end of the roll without loss of adhesion, according to report. The new corrugated container opens simply by a tear tape.

The adhesive is easy to handle when applied, tears easily across the width and lengthwise, yet has high tensile strength adequate for any use, including supportive strapping and skin traction on fractures. It sticks quickly and firmly when applied, has minimum slippage and releases cleanly. Curity adhesive is said to lower the irritation and allergic reaction and to have a margin of safety exceeding both U.S.P. and Federal strength standards. It is offered in three types: Arro, Wet-Pruf and Regular. **Bauer & Black, 309 W. Jackson Blvd., Chicago 6.**

For more details circle #165 on mailing card.

Pharmaceutical Graduates in All Standard Sizes

Latest specifications for liquid measuring devices, as published by the National Board of Standards, are used in the new series of pharmaceutical graduates added to the Armstrong line of prescription glassware. The Armstrong N.B.S. 40 Phenix Graduates are available in all standard sizes and simplify accurate



measuring, even in small quantities. A digest that lists the main divisions of the new standards publications is offered by the manufacturer. **Armstrong Cork Co., Lancaster, Pa.**

For more details circle #166 on mailing card.

WHAT'S NEW

Biological Refrigerator Has Center Cooling Coil

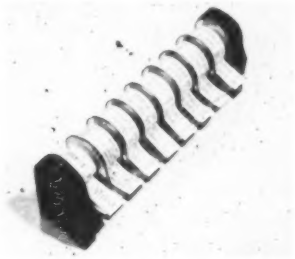
Stainless steel is used for the interior and the exterior of the new BR-148 Biological or Pharmaceutical Refrigerator developed by Jewett. The 35-cubic foot capacity unit has a central mullion cooling coil providing even temperatures throughout. Standard adjustable shelving with stainless steel perforated bottom drawers in various sizes provides efficient storage and circulation in the attractive, easily cleaned unit. **Jewett Refrigerator Co., 2 Letchworth St., Buffalo 13, N.Y.**

For more details circle #167 on mailing card.

Time Saving Labels for Every Department

Time Labels for use in central service, laboratory, nursing service and other departments of the hospital are now available mounted on Time dispensers. Designed to save time and prevent errors, the labels are self-sticking and vinyl coated. Printed labels save time in marking gloves, hypodermic needles, surgical packs and other items, and special labels carry special messages to ensure delivery or return to departments.

The new multiple dispenser carries a series of labels on rolls, for a variety of purposes. Labels are pulled to the desired length and neatly cut off for quick adhering to surfaces, to assure proper marking of materials, save time in writing instructions and seal and label in one operation. They can be used on patients charts, sterile solutions, central service items, blood banks, laboratory, for drugs, infant feeding, therapeutic diets and to identify foods. **Professional Tape Co., Inc., Box 41, Riverside, Ill.**



For more details circle #168 on mailing card.

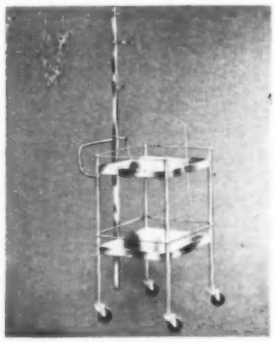
Concentrated Detergent in Liquid Form

Oakite Liqui-Det is a new detergent, containing no soap, which goes instantly into solution in hard or soft water, hot or cold. It develops copious suds which penetrate and loosen most common soils in a short time. The report states that it can be used repeatedly without rinsing, and without causing any build-up of film or discoloration. Liqui-Det is designed to be safe for use on every type of surface while being pleasant to the hands. Good results from low concentrations make the product economical in use. **Oakite Products, Inc., 1280 Rector St., New York 6.**

For more details circle #169 on mailing card.

Utility Table and Stand in Single Mobile Unit

The S-3659 Clysis Table is a combination utility table and irrigator stand. Of all stainless steel construction, the unit is mounted on ball bearing swivel casters with three-inch wheels of conductive rubber for ready mobility with safety in the operating room. It is equipped with a convenient push handle.



The telescoping rod is adjustable from 65 to 85 inches with an automatic slide-lock control. It is equipped with two stainless steel spring-clip holders for clysis bottles and a hook for tubing. Stainless steel guard rails surround the reenforced and sound-deadened table top and lower shelf. **Shampaine Company, 1920 S. Jefferson Ave., St. Louis 4, Mo.**

For more details circle #170 on mailing card.

Duplex Outlet Is Weatherproof

A duplex outlet complete with cast aluminum mounting box is made weatherproof by cover and plate gaskets plus a rubber grommet which seal the entire installation against severe weather conditions. The 15 ampere, 125 volt unit is quickly installed as it is only necessary to drill one hole for mounting. A third wire ground may be added to the outlet if necessary. **Pass & Seymour, Inc., Solvay Station, Syracuse, N.Y.**

For more details circle #171 on mailing card.

(Continued on page 198)

A NURSE *CAN* BE IN TWO PLACES AT ONCE

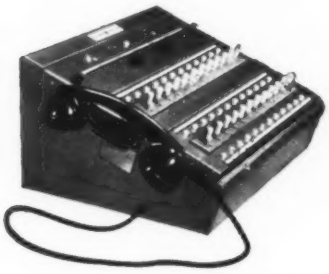
when you install Edwards Audio-Visual Call System

Now your nurses can operate more efficiently, give patients quicker, better service and actually lower your operating costs! Once you have installed the Edwards Nurse-Patient Call System you'll save your nurses countless unnecessary steps to the bedside by determining patient needs and the urgency required for each call right at the nurses station. As a result, your nurses will add hours of extra patient-care time to each day. And your patients will appreciate this quicker contact with the nurse. The many hospitals that have already adopted this new Edwards system report their operating costs have been reduced by this efficient method.

By simply touching a conveniently placed button the patient is in immediate communication with the nurse. Whisper-sensitive control permits bedside supervision from the nurses station. The automatic reset feature permits the nurse to reset the calls from her station.

All components are of high quality design perfectly matched for distortion free communication. Exclusive "plug-in" construction permits your maintenance men to make rare replacements in seconds, eliminates interruptions of service. Attractive stainless steel room stations retain their enduring quality.

This time-and-cost-saving Edwards Audio-Visual System, complete with all features, can be added to an existing visual call system at surprisingly low cost. For full information, write Dept. MH-2, Edwards Company, Inc., Norwalk, Conn. (In Canada: Edwards of Canada, Ltd., Owen Sound, Ont.)



DESIGN • DEVELOPMENT • MANUFACTURE

EDWARDS

Specialists in Signaling Since 1872

WHAT'S NEW

Sundry Jars and Rack Are Custom-Designed

The Glasco set of sundry jars and rack has been custom-designed after careful

research to fill the need for this type of unit. The complete set includes five glass jars, stainless steel or colored lids, stainless steel rack and wall brackets. It is available in durable stainless steel or in three colors: white, pink and blue. The colored units have enameled steel closures. Jar labels are marked in ceramic color to identify jars for tongue depressors, bandages, gauze, applicators and cotton. Through the multiple-use handles, it can be fitted over a special bracket for hanging on wall or partition, as well as being placed on a table or cabinet. **Glasco Products Co., 111 Canal St., Chicago 10.**

For more details circle #172 on mailing card.

Plastic Holder for Disposal Bags

The Moro Disposal Bedside and Utility Bags are held in place by patented permanent vinyl plastic holders. The holder has adhesive backing which can be attached readily to bed frame, wheel chair,

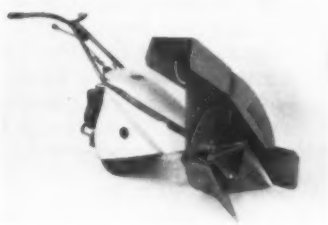
bedside table, operating room table or other smooth areas. The holders will adhere to any surface, even after autoclaving, and can be used again and again.

Bags are easily slipped into the holders which hold three or more bags at one time, reducing nursing calls and making a new bag always ready for use. Bags are wax permeated throughout, making them impervious to moisture, have convenient stay-open design with quick closing for disposal. **George Demain & Co., 3611 W. Pico Blvd., Los Angeles 19, Calif.**

For more details circle #173 on mailing card.

Lawn Maintenance Unit Has Snowthrower

The Jari Junior power unit with Snowthrower attachment handles up to 300 shovelfuls of snow per minute by throwing the snow in one direction. A special



raker bar cuts up packed snow into small pieces which can also be easily thrown aside. The attachment can be used through drifts up to 18 inches and deeper.

The snowthrower attachment is easily removed and replaced by a lawnmower, power sprayer, sickle bar mower and tiller-cultivator. The power unit features an aluminum 1.75 h.p. engine, adjustable handlebars and clutch control rod which provides positive forward drive. **Jari Products, Inc., 2990 Pillsbury Ave. S., Minneapolis 8, Minn.**

For more details circle #174 on mailing card.

(Continued on page 200)

what more and more radiologists are discovering about

ILFORD RED SEAL FILM

Here is the X-ray film everyone is talking about. It's Ilford Red Seal—a film whose exceptional *high speed* reduces the risk of involuntary movement, whose *gradation* produces the widest possible range of opacities, whose *freedom from fog* provides sharper, cleaner radiographs. These are but a few of the reasons why Ilford Red Seal Film is gaining in preference among radiographers everywhere. Try this remarkable film at your earliest convenience. Contact your regular supplier, or write to the address below.

Specify Ilford Red Seal X-ray Film

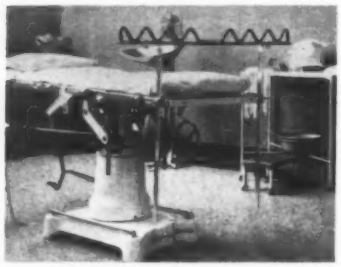
ILFORD INC., 37 West 65th Street, New York 23, N. Y.

Your Source in Canada is W. E. BOOTH CO. LIMITED, 12 Mercer Street, Toronto 2B, distributors for Ilford Limited

WHAT'S NEW

Leg Holder for Operating Table

Designed by Richard W. Zollinger, M.D., of Columbus, Ohio, the new Zimmer operating table holder for two legs is designed to simpilfy the labor of surgeon or assistant in preparation of the extremities for venous strippings. The holder for two legs consists of three main parts: the main piece or holder and the two side bars which can be fitted quickly to practically any operating table. The design of the holder makes access to the short saphenous system easy, without repositioning the patient on the operating table. It is also useful for other soft tissue surgery on the lower extremities and can be used for holding an extremity for approximation of a fractured patella. **Zimmer Mfg. Co., Warsaw, Ind.**



For more details circle #175 on mailing card.

Steel Suture and Wire Mesh for Reconstructive Surgery

Two companion products for reconstructive surgery are announced by Ohio. One is a new multifilament stainless suture made of several strands of specially treated stainless steel wire twisted together to form a smooth, slender suture of maximum strength and a high degree of flexibility. The suture ties easily without kinking or curling, giving permanent anchorage of reconstructive mesh. It will not corrode, is unaffected by sterilization, and there is no swelling, stretching or breaking. The non-magnetic, non-electrolytic, non-irritating suture makes small stitch punctures and resists fragmentation, fracture and disintegration.

The second product, a companion to the suture, is a stainless steel foundation wire mesh made of a special alloy of steel, nickel, chromium and molybdenum. It is available in eight different weaves from a stiff, heavy screen to a soft wire cloth for permanent repair of all areas of the body. The mesh allows growth of tissue through all weave sizes and is basically inert, non-electrolytic and non-irritating. It aids serum elimination, is flexible and/or readily shaped, and has high tensile strength. **Ohio Chemical & Surgical Equipment Co., Madison 10, Wis.**

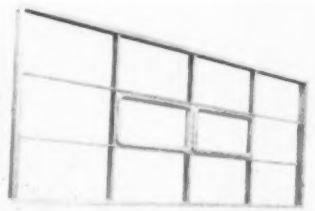
For more details circle #176 on mailing card.

Continued on page 202

Aluminum Window System Features Simple Construction

Simplicity of construction with economy in first cost and installation are features of the new Geyser aluminum bar window system. Narrow muntins give a neat, trim appearance with flat, unornamented exterior surfaces for modern appearance and easy cleaning. The Geyser glazing system leaves no facing putty exposed.

Installation may be made from either the inside or the outside of the structure and permits random spacing of mounting holes in the structure for attachment of subframe. The new Series 7 "Contemporary" design is available in any size to meet architectural requirements.



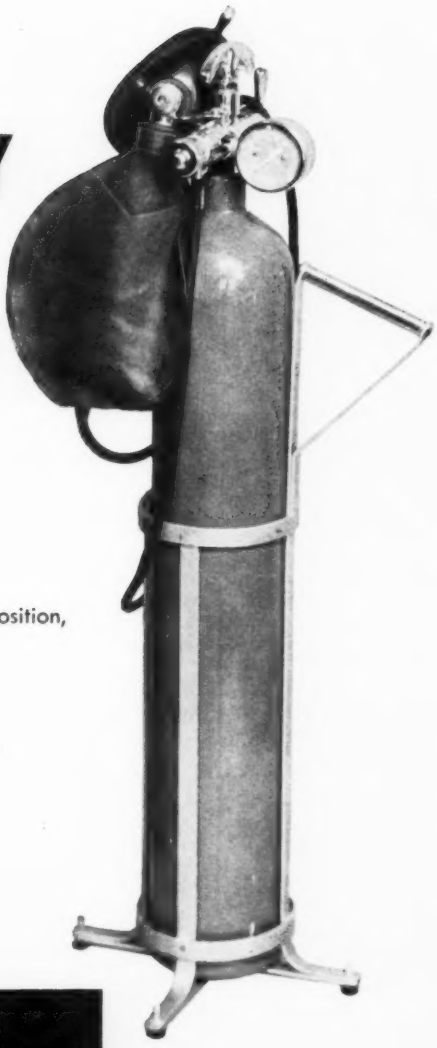
Standard sizes range up to 12 feet six inches in height with mullion spacings of either three feet six inches or four feet. **E. K. Geyser Co., 915 McArdle Roadway, Pittsburgh 3, Pa.**

For more details circle #177 on mailing card

new! safe!

EMERGENCY OXYGEN and RESUSCITATION UNIT

by McKesson



A new, easily-portable, perfectly-balanced unit.
Many outstanding safety and economy features.
Uses either D or E size cylinders.

New, improved flow-valve graduated with adjustable zero position, always indicates approximate flow rate.
Impossible to open control-valve more than one turn.

No danger of excessive flow-rate, should valve be left open when attaching full cylinder. Pin-indexed yoke precludes possibility of attaching improper gas.

For resuscitation, squeezing re-breathing bag forces oxygen into patient's lungs.

many other important features

Rubber feet prevent marring any highly polished surface.

Weight of stand and valve complete, 5¼ lbs.

McKesson

EMERGENCY OXYGEN AND RESUSCITATION UNIT

Contact your McKesson Dealer or write us today for complete information, specifications and prices.

McKESSON APPLIANCE COMPANY • TOLEDO 10, OHIO

WHAT'S NEW

Thermo-Fax Machine Copies Books and Papers

One of the new models of the Thermo-Fax copying machines is designed to copy material from books, magazines, newspapers and other bulky units, as

well as any other printed, written or typed material. The "Premier" machine has an 8 by 14 inch copy area. Copy paper is placed on the machine, then the book or other material to be copied is placed face down on top, the cover is lowered and a button pushed. When the copying cycle is completed, the light shuts off and the cover is raised automatically. The book, or other material, is removed and the copy is ready for immediate use. **Minnesota Mining & Mfg. Co., 900 Fauquier Ave., St. Paul 6, Minn.**

For more details circle #178 on mailing card.

Three-Process Unit in Electric Food Handler

Juicing, slicing and shredding are handled in the new Oster unit which attaches to the base of the Osterizer li-

quefier-blender. A separate disc is provided for each operation of the three-process unit. Almost all fruits can be made into juice with the juicer. In addition to oranges, juice can be prepared from apples, plums, mangos, berries, papayas, grapefruit and fresh pineapple. Vegetables and fruits are quickly and efficiently sliced or shredded with the special discs provided for those purposes. The appliance is simple to operate and is designed for easy cleaning. **John Oster Mfg. Co., 5055 N. Lydell Ave., Milwaukee 17, Wis.**

For more details circle #179 on mailing card.

(Continued on page 204)

Does OXYGEN THERAPY support itself in your hospital?

IF your present oxygen therapy is a liability, LINDE can help you make it self-supporting—even an asset. With more than 25 years of experience in the hospital field, LINDE has shown hundreds of hospitals how to bring paying efficiency to oxygen administration.

1. A LINDE specialist studies the conditions under which oxygen is administered in a hospital.
2. He makes recommendations for correcting any faulty practices that are found and assists in carrying out these recommendations.
3. He works with the business office to establish a system of charges for oxygen therapy that are fair to both the patient and the hospital.

To start the ball rolling in your hospital, just call your LINDE distributor, or write your nearest LINDE office.

Linde Trade-Mark

LINDE AIR PRODUCTS COMPANY

A Division of Union Carbide and Carbon Corporation

30 East 42nd Street UCC New York 17, New York

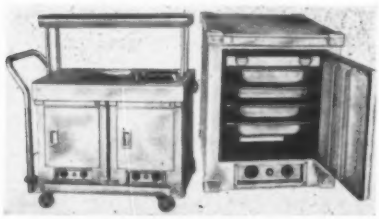
Offices in Other Principal Cities

In Canada: Linde Air Products Company, Division of Union Carbide Canada Limited, Toronto

The term "Linde" is a registered trade-mark of Union Carbide and Carbon Corporation.

WHAT'S NEW

Redi-Serv Food Conveyors Used Singly or in Groups



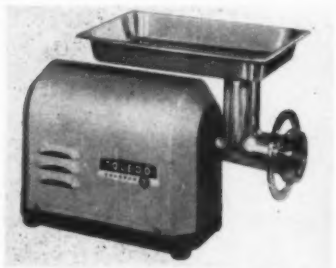
The Redi-Serv Food Conveyor is a scientifically insulated unit with Chromalox electrical heating elements and Robertshaw thermostat, wired for 110 volt current, carrying standard size stainless steel food pans. Individual units can be used for storage or mounted on carrier or wheels for carrying to floors or other buildings. For large service needs the Redi-Serv units are mounted on trucks, complete with serving top, in units of two, three or four, depending upon the number of meals to be served. Units are readily adapted for cold food service by incorporating the Redi-Serv Cold Plate.

Redi-Serv Food Conveyor units are offered in three sizes; Junior, Standard and King sizes. All units are engineered and built to provide maximum efficiency in temperature retention and to withstand heavy duty service. The formed construction gives extreme rigidity to the cabinets, yet there is no metal-to-metal contact between the inner and outer shells which might affect temperature retention. Cabinets are re-enforced with cast aluminum corners for protection against damage and to permit steady stacking of one cabinet on another. The flush door construction and positive locking device are other features of the units. A label holder for inserting cards for listing contents or giving destination is also a part of each unit. Units are lined with high tensile aluminum and are available in either stainless steel or polished aluminum exteriors. Rigid handles at the top of the front and rear panels of the cabinets facilitate handling. **Precision Metal Products, 524 Wyatt Bldg., Washington 5, D.C.**

For more details circle #180 on mailing card.

Small Unit Meat Chopper Has Maximum Cutting Capacity

A new ⅓ h.p. Toledo Meat Chopper can chop nine pounds of meat per minute. A spiral fluted cylinder and deep fluted feed screw give Model 5125 its maximum cutting efficiency.



Costly breakdowns resulting from a sheared cylinder pin are eliminated by the use of precision ground flat sided plates. The unit may be conveniently handled from either side as the switch is mounted at the end opposite the cutting group. Model 5125 is finished in durable silver hammertone and is regularly supplied with a large capacity safety-type feed pan and stomper. **Toledo Scale Co., 1023 Telegraph Rd., Toledo 12, Ohio.**

For more details circle #181 on mailing card.

Matched Tray Set Brightens Food Service

The "Aristocrat" line of tray covers and matching napkins is embossed with a green and gold design to add a cheerful note to patient trays. Tray covers of extra-heavy stock are available in two sizes with a selection of two and three-ply or semi-crepe matching napkins. **Wisconsin Tissue Mills, Menasha, Wis.**

For more details circle #182 on mailing card.

Continued on page 206)

Maysteel

Unit Design Flexibility Gives You Cost Advantages

CASEWORK & PATIENT ROOM WARDROBES

Neat, sanitary, space-saving Maysteel built-in patient room wardrobe cabinets offer wide combination of standard units to fit your room or ward arrangements.

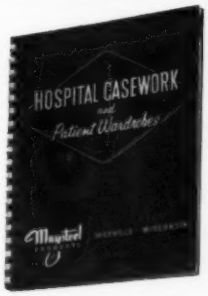
For Every Hospital Working Area—Instrument Rooms —Surgical—Treatment Rooms—Utility— Central Sterilizing—Corridor Storage —Nurses Stations—Storage and Supply

Including:

CABINETS & CASEWORK
CABINETS: BED PAN
CABINETS: BEDSIDE
CABINETS: BUILT-IN
CABINETS: COUNTER & DESK HIGH
CABINETS: DRUG AND NARCOTIC
CABINETS: INSTRUMENT
CABINETS: WALL (WITH SINK)
CABINETS: PRESCRIPTION
COUNTERS: STORAGE (ALL-PURPOSE)
HOLDERS: CHART
*PLANNING SERVICE: CABINET & CASEWORK
SINKS: ACID-RESISTANT
TABLES: WORK, UTILITY
TOPS: TABLE, COUNTER, FURNITURE
TOPS: TABLE & WORK SURFACE (PLASTIC)
UTILITY UNITS: PATIENTS ROOM (BUILT-IN)
WARDROBES: BUILT-IN
CABINETS: CHART
CABINETS: CLASSROOM
CABINETS: DARK ROOM
CABINETS: SPLINT
CABINETS: WARDROBE
LOCKERS: NARCOTIC
SHELVING: METAL
SINK TOPS: PLASTIC
SINKS: CORROSION RESISTING METAL
DESK & CHART CABINETS: (NURSES STATION)
FURNITURE: (NURSES STATION)

Maysteel Work Table with Sorting Bins for Central Sterilizing

Versatile (island) unit available with stainless steel bins and top, choice of base units, drawers, open or closed shelves, accessible to both sides. 48" wide, in varying lengths.



NEW MAYSTEEL CATALOG AND PLANNING GUIDE

Illustrates casework, wardrobes, components, room plans—for new hospital planning or remodelling. WRITE FOR YOUR COPY

Representatives in Principal Cities

MAYSTEEL PRODUCTS INC.

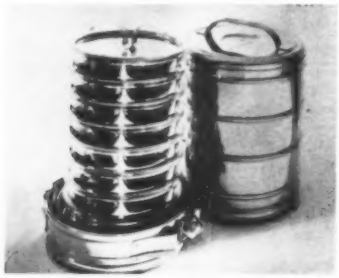
SALES OFFICE 738 N. PLANKINTON AVE., MILWAUKEE, WIS. PLANTS—MAYVILLE, WIS.

Maysteel CASEWORK

WHAT'S NEW

"Multi-Meal" Containers Assure Hot Food Service

The new Mealpack Models 8-MM and 8-MM-E "Multi-Meal" containers recently



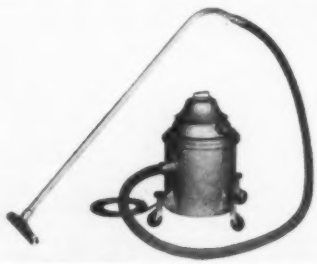
introduced are designed to simplify the centralized vacuum sealing, and the decentralized serving of hot main courses of food without re-heating. Eight partitioned Pyrex Brand dishes, each containing a full main course of food, fit on top of each other into a double-walled insulated stainless steel base. A similarly constructed stainless steel cover fits over the dishes and is clamped to the base, providing a compact, easily handled eight-meal unit.

Operating on a vacuum principle, the 8-MM model is designed to keep meals hot for from one to two hours, and the 8-MM-E, electrically heated, can maintain temperature indefinitely through a built-in thermostatic control. When removed from the container, each dish is placed in the new Mealpack durable Model CTS Serving Tray where it locks against turning or side movement. Other courses for each meal, as well as cutlery, seasoning, napkins and other items, are recessed into each tray. **Mealpack Corp., Evanston, Ill.**

For more details circle #183 on mailing card.

"Turbo-Vac" Cleaner for All Maintenance Jobs

The new Kent "Turbo-Vac" vacuum cleaner is designed to maintain rugs, car-



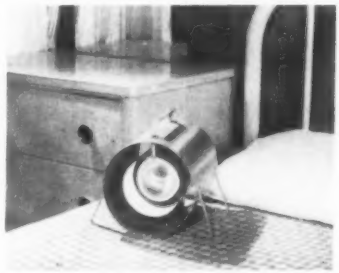
pets, walls, wet and dry floors and even boiler cleanout at low cost. Model 45, featuring high volume air intake for fast cleaning, has a capacity of ⅔ bushel or five gallons. The unit rolls easily in any direction on four ball-bearing swivel casters and incorporates all Kent construction advantages. **The Kent Co., Inc., 736 Canal St., Rome, N. Y.**

For more details circle #184 on mailing card.

Radiant Heating Unit Prevents Burns

The new Heal-Lite is a radiant heating unit so designed that it cannot be upset. Constructed of lightweight aluminum alloy, the Heal-Lite has an outer shell of aluminum surrounding an inner core that holds the radiant lamp housing. The air space between the two shells acts as an insulator to prevent the patient from coming into contact with the lamp, thus preventing burns and electric shock injury. The two wide foundation legs keep the unit upright in any position so that it cannot upset.

The completely open construction of the unit permits thorough cleaning between uses. It may be immersed in water for washing and may also be autoclaved. There are no sharp edges protruding to injure the patient. The Heal-



Lite is designed for post-operative perineum heat treatments and for wide application wherever concentrated radiant heat would be beneficial. **J & L Development Co., Tompkins St., Cortland, N. Y.**

For more details circle #185 on mailing card.

Out-of-Sight Installation with Automatic Door Operator

The Stanley Hydro-Magic Door Operator is easily installed under door thresholds with no alterations in door frames or extensions under jambs as the operator is only four by seven by 25⅛ inches. The smooth hydraulic operation speeds traffic flow and the rate with which the door opens and the time it stays open can be regulated. The unit can be used with the Magic Eye control, push plate, hardware controls or the Magic Carpet Control.

The Magic Carpet Control is now available in color with a complementary clip-on molding for attractive appearance of entrance-ways. The carpet controls are constructed of molded plastisol and come in blue, green, brown, and gray while the clip-on moldings are made of extruded aluminum alloy. **The Stanley Works, New Britain, Conn.**

For more details circle #186 on mailing card.

(Continued on page 208)

HERRICK STAINLESS STEEL* REFRIGERATORS

Unmatched for Dependable Performance

Highest quality materials and fine craftsmanship combine to make HERRICK Refrigerators completely dependable. Low cost, year-after-year performance is assured, as are rugged durability and maximum convenience. Write for the name of your nearest HERRICK supplier. He is ready to serve you.

*Also available with white enamel finish.

They both agree . . . HERRICK trouble-free performance is tops.

HERE'S WHY:

- **Oversize Cooling Coil** — Provides correct temperature and humidity. Assures faster recovery and uniform temperatures throughout the refrigerator for superior results.
- **Heavy-Duty Condensing Unit**—Properly balanced with cooling coil for maximum life and service.
- **Large Compressor Compartment**—Contains sufficient ventilation openings to give best condenser cooling.
- **Super-Efficient Insulation**—Semi-rigid Fiberglas 2½ lb. density, 3" thick in walls, 3⅝" thick in doors.

...plus many other HERRICK Extra-Value Features. Ask about them.

HERRICK Model TS566

See us at the Restaurant Show, May 7-11. Booths D92 and D94.

HERRICK manufactures a complete line of:

Reach-In Refrigerators

Commercial Freezers

Walk-In Coolers

HERRICK REFRIGERATOR COMPANY • Waterloo, Iowa
Dept. H., Commercial Refrigeration Division

Typical Installations

HERRICK Refrigerators are Performance-Proved at:

St. John's Hospital
Springfield, Mo.
Cleveland Clinic Foundation
Cleveland, Ohio
Cook County Hospital
Chicago, Illinois
St. Elizabeth Hospital
Youngstown, Ohio
Memorial Mission Hospital
Asheville, N.C.
Foundation Hospital
New Orleans, La.
Menninger Foundation
Topeka, Kansas

WHAT'S NEW

Heavy-Duty Range Has Steel Top

The smooth, nickel-plated steel top of the new Hotpoint Superchief range has

three heavy duty round hot plates and two super-fast Calrod units. The "Sealed-Heat" oven base with a temperature range from 200 to 500 degrees has top and bottom heating elements independently controlled. The all-purpose oven is suitable for any baking or roasting operation. Each of the five top cooking units will maintain any of three heats.

The heavy-duty hot plates are made of rugged cast metal and are designed for stockpot work as well as pan cooking. The Calrod units have quickly removable reflector pans and heat instantly with quick response to changes in switch positions. The Superchief is 36 inches wide and has dimensions matching those of the Hotpoint Superline ranges for installation in series. **Hotpoint Co., Commercial Equipment Dept., 227 S. Seeley Ave., Chicago 12.**

For more details circle #187 on mailing card.

Steel Curtain Wall Panels in Several Styles

Several styles and weights of steel curtain wall panels are now available either insulated or non-insulated. They are easily applied by means of metal clips fastened by a hand-operated clinching tool, eliminating the need for welding. The new curtain wall panels have "Stran-Satin" finish, a zinc coating process recently developed which combines attractiveness with the time-proven qualities of zinc coating.

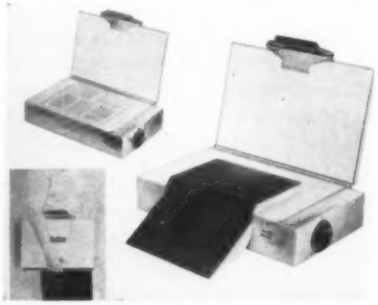
Another new Stran-Steel product is the 10 and 12 inch joists. While still retaining the nailable feature, the new joists can be used for spans up to 30 feet, making possible the application of these members to a broader range of building projects, including one-story buildings. The constant depth of the joists facilitates a simple cantilever detail for overhead. **Stran-Steel Corp., Div. National Steel Corp., Detroit 29, Mich.**

For more details circle #188 on mailing card.

Book Copier Is Compact Unit

The Apeco Panel-Lite Copier is a new compact unit designed especially to copy pages from books and magazines. It is styled to give snug contact on any bound page to make a sharp, clear copy of the entire page from the gutter to the outer edges. Similar exact copies can also be made from any other typed, written, printed or other material requiring a flat bed printer.

The lightweight, compact unit is engineered to be used with the Apeco Autostat as well as other processing methods.



Made with a built-in automatic timer, it measures 19½ by 13 by four inches. **American Photocopy Equipment Co., 1920 W. Peterson Ave., Chicago 26.**

For more details circle #189 on mailing card.

(Continued on page 210)

WHAT'S NEW

Laundrite Extractor in 25-Pound Capacity

Stability and safety are special features of the new Laundrite Extractor in the

25-pound capacity. The heavy basket, machine base and three anchor points on the outside of the base give the Laundrite stability in extracting out-of-balance loads without excessive vibration or special foundations. The stainless steel extractor has no motor overhang and requires minimum floor space. Both manual and automatic controls have positive safety features. **Troy Laundry Machinery Div., American Machine and Metals, Inc., East Moline, Ill.**

For more details circle #190 on mailing card.

Surgical Monitor Offered in Monitorscope

Advanced electronics has made possible the new Monitorscope, an instrument for monitoring physiological functions during surgery, or at any other time desired. Instantaneous observation of electrocardiograms, electroencephalograms or electromyograms of a patient is possible in the operating room or in the laboratory with the Monitorscope. Either two or four channels may be operated independently or simultaneously to make critical information instantly available in visual form. Easy readability at a considerable distance is possible with the 17-inch screen and large complexes.

The mobile unit, mounted on casters,

can be used anywhere in the operating room. Special safety requirements for the operating room are met and the frame, with soft rubber casters for quiet transport, can be raised or lowered as required. The Monitorscope is equipped with an output jack for recording as well as monitoring. Special models are available for special uses. **Essential Electronics Corp., 1011 Power Ave., Cleveland 14, Ohio.**

For more details circle #191 on mailing card.

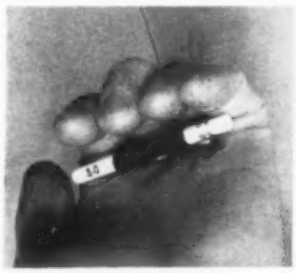
Wet-Dry Vacuum of Heavy-Duty Construction

Premier features heavy-duty construction for long-life in its new Model P-905 Master-Vac. The rugged steel tank finished in baked enamel holds 10 gallons liquid or one bushel dry dirt. The Master-Vac is 32¼ inches high, 21½ inches in diameter weighing 38 pounds. A complete line of accessories is available. **Premier Co., 755 Woodlawn Ave., St. Paul 1, Minn.**

For more details circle #192 on mailing card.

Readi-Wound Ligature Reel Fits in Palm of Hand

Made in just the right size to fit comfortably in the palm of the surgeon's



hand, the new dry sterile Readi-Wound Ligature Reel saves time in preparation and in use. The size of the suture is clearly marked on every Deknatel Reel and is readily seen, no matter how the reel is held. The reel is easy to handle during surgery and each reel, packed dry sterile, contains fifteen feet of Deknatel Silk suture in sizes 5–0 through 0. The silk is specially machine wound to prevent kinking and snarling during use. **J. A. Deknatel & Son, Inc., 96-20 222nd St., Queens Village 29, N. Y.**

For more details circle #193 on mailing card.

Hot Cocoa By Adding Water

Carnation's Instant Chocolate Flavored Drink dissolves instantly in hot water to make a rich chocolate flavored cocoa. It may also be added to ice water for a cold chocolate drink. Both drinks have all the milk nutrition and creamy flavor of fresh chocolate drink. The mix is available in three sizes: single serving foil package, a portion control package reconstituting to one gallon, and a 25 pound size. **Carnation Co., 5045 Wilshire Blvd., Los Angeles 36, Calif.**

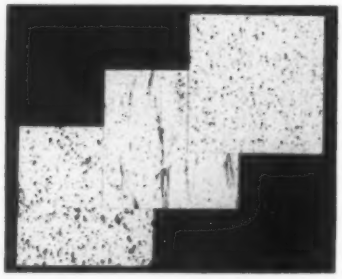
For more details circle #194 on mailing card.

(Continued on page 212)

WHAT'S NEW

Additional Colors In Floor Tile

Three new numbers have been added to the Azphlex vinylized tile line. They include Canyon Pink, P-721, a terrazzo tone design with salmon pink back-



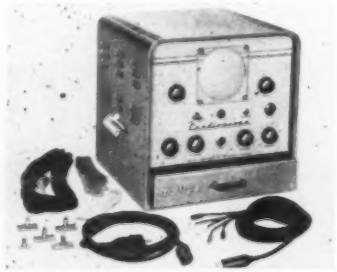
ground; Fresco Green, P-722, a terrazzo tone with a green background, and Horizon Gray, P-736, a marble tone with light blue background with blue and silver-gray striations. All three are available in nine by nine inch sizes and $\frac{3}{32}$ inch thickness with Horizon Gray also available in $\frac{1}{8}$ and $\frac{3}{16}$ inch thicknesses. **Azrock Products Div., Uvalde Rock Asphalt Co., Box 531, San Antonio, Texas.**

For more details circle #198 on mailing card.

Cardiological Instruments in Advanced Design

Dallons offers new cardiological instruments of advanced design. The new Cardioscope provides stability of image and simplicity of operation. It is entirely Underwriters Laboratories' approved, according to the manufacturer, and gives immediate interpretation of any heart deviation during surgery. It has a five foot stand to bring it within easy vision of the entire surgical team. The Cardiophone, another new unit, warns audibly of impending danger.

Two other new instruments include the Dallons Defibrillator used to stop ventricular filbrillation and the Cardiac Pacer for fast, effective and safe external emergency treatment of cardiac accident or weakness, ventricular standstill and



cardiac or circulatory arrest. Automatically timed electrical stimulation may be used without time limitations in the external regulation of cardiac rhythm. **Dallons Laboratories, Inc., 5066 Santa Monica Blvd., Los Angeles 29, Calif.**

For more details circle #199 on mailing card.

Concentrated Painter Colors for Tinting Five Gallon Lots

A new tinting system known as Pittsburgh Maestro Concentrated Colorants consists of nine heavily concentrated colors and black and white designed to speed up on-the-job tinting of all kinds of paints in five gallon lots. A wide range of tones and hues can be achieved with the tube colorants which can be used in oil, alkyd, PVA or latex emulsion bases. The concentrated colors are packaged in eight and 16 ounce tubes and only small amounts need be used for large quantity mixing. A key to quick mixing of the 300 decorator colors in the system is included. **Pittsburgh Plate Glass Co., 632 Ft. Duquesne Blvd., Pittsburgh 22, Pa.**

For more details circle #195 on mailing card.

ASR Surgical Razor Withstands Repeated Sterilizing

A special design, featuring the comb-tooth which has been found efficient for

pre-operative shaving of body areas, is incorporated into the new ASR Hospital Razor. Constructed of chrome-plated brass, the double-edge razor is capable of withstanding repeated sterilization. A special introductory offer of six of the new razors free with the purchase of 5000 double-edge blades for hospital use is being made by the manufacturer. **American Safety Razor Corp., 380 Madison Ave., New York 17.**

For more details circle #196 on mailing card.

Water-Emulsion Floor Wax Reduces Rewaxing Frequency

A new Johnson wax called Waxtra is a water-emulsion formula with a high solid content which gives premium performance and reduces rewaxing. Other advantages claimed for Waxtra include more brightness when first applied and after each buffing, longer wear, more slip-retardant properties, greater dirt resistance and absence of streaking. Waxtra is available in five, 30 and 55 gallon drums and is applied in the same manner as other self-polishing floor waxes. **S. C. Johnson & Son, Inc., Racine, Wis.**

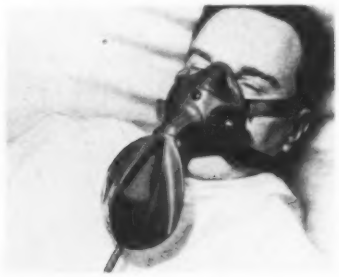
For more details circle #197 on mailing card.

(Continued on page 214)

WHAT'S NEW

Four-Way Oxygen Mask Has Universal Fit

Any sized face can be fitted with the new Model No. 24840 oxygen therapy



mask. It is so designed as to be used in four ways: as a reservoir-type mask, as a straight rebreathing-type mask, as a positive-pressure mask, and as a super-saturated oxygen therapy mask. It is quickly and simply disassembled for cleaning and all normal sterilization technics, either with steam or cold, are applicable. Embedded wire inserts simplify fitting the mask to conform to facial contours of any size or shape of face, ensuring a close fit. Maximum life of the bag and facepiece are assured by use of double and triple thicknesses of rubber at critical points. **National Cylinder Gas Co., 840 N. Michigan Ave., Chicago 11.**

For more details circle #200 on mailing card.

High Speed Centrifuge Generates Little Heat

The new Spinco Model K Centrifuge provides maximum speed of 25,000 rpm with less than five degress C. rise in temperature. This feature is accomplished through the use of a special design, including an insulating layer bonded to the rotor. Operation can thus be carried on indefinitely at room temperature without refrigeration. For reduced temperatures, the unit can be operated in a cold-room. A timeclock sets the speed and duration of the run. **Spinco Div., Beckman Instruments, Inc., Stanford Park, Palo Alto, Calif.**

For more details circle #201 on mailing card.

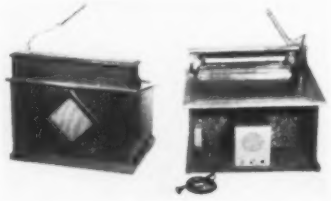
Suture Guide Minimizes Trauma

Speed, accuracy and a minimum of trauma are advantages claimed for the use of the new L'Esperance Suture Guide. The efficient instrument pinpoints the exact spot to be sutured, then centralizes the bite of the forceps and the needle puncture in the same spot. Use of the instrument is said to assure dependable, shallow suturing without tears along the incision edge, and to prevent the possibility of damage to structures not to be sutured. **United Surgical Supplies Co., 154 Midland Ave., Port Chester, N.Y.**

For more details circle #202 on mailing card.

Microphone-Lectern In One Unit

A portable lectern for use on table or desk is now available with built-in high quality sound and amplification, ready to be plugged into any standard electric outlet. The unit is complete with speaker, amplifier, microphone and light. The no-glare reading light is adjustable. The completely adjustable microphone is of the finest quality and the built-in high fidelity speaker is designed for use with up to 500 people. All switches and buttons for regulating the light, speaker and microphone are on the unit, readily available to the speaker who can regulate the sound for volume and quality of tone. The lectern, with reading shelf, is sturdily constructed of wood with walnut

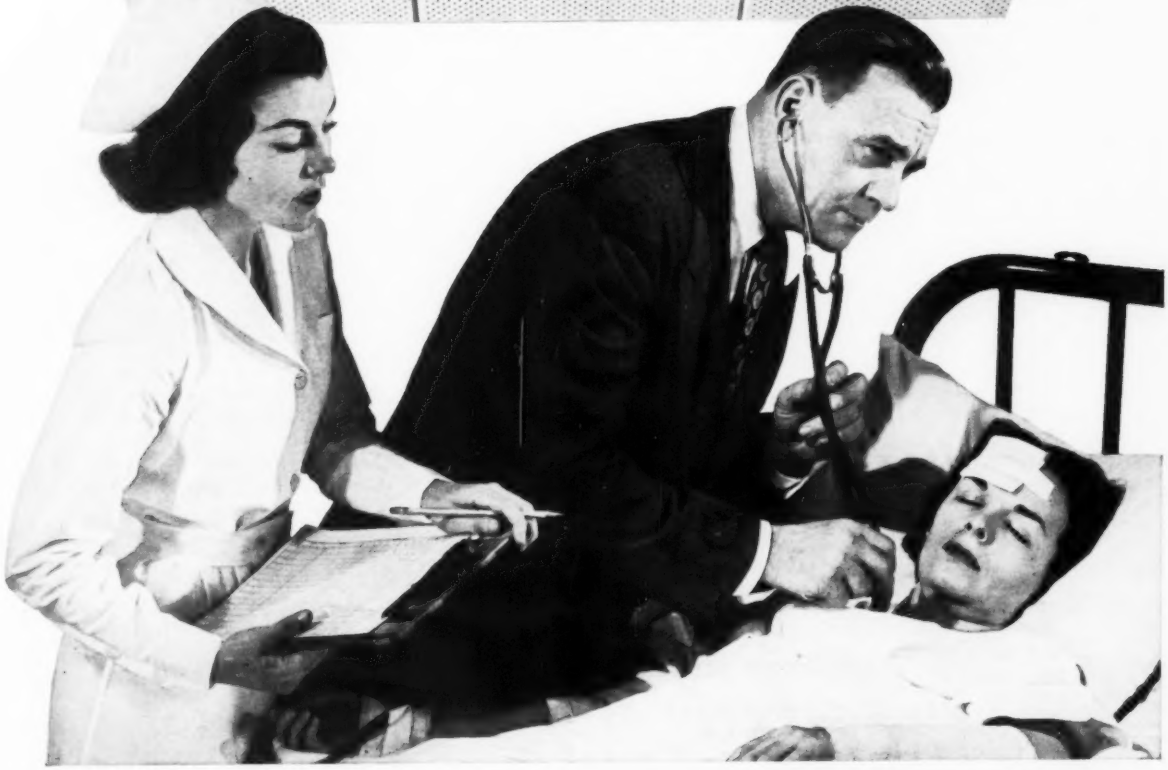


finish. It is a completely portable unit for teaching, lectures and other uses, as well as for use in closed-circuit telecasts. **American Communications Corp., Box 65, Eureka, Ill.**

For more details circle #203 on mailing card.

(Continued on page 216)

QUIET IS IMPORTANT NOW!



Noncombustible Sanacoustic* Ceilings provide strength-building, relaxing quiet so necessary to patients' progress

• In modern hospitals today, noise control is considered essential to the welfare of patients. Quiet speeds recovery.

Sanacoustic* Ceilings offer hospitals one of the most effective methods of combating disturbing noise. They may be applied with *new construction* or *over existing ceilings* and are easily removed for access to services. Sanacoustic units are not only highly efficient in sound absorption, but they are also sanitary and noncombustible. They are made of perforated metal panels backed up with a fireproof, sound-absorbing element. The baked-enamel finish is easy to keep clean, and the ceiling can be washed or repainted without loss of efficiency.

Other Johns-Manville Acoustical materials include perforated Transite* Acoustical Panels, recommended for those areas subject to excessive moisture; Permacoustic*, a textured noncombustible tile; and Fibretone*, a budget-priced drilled fibreboard unit.

For a free survey of your problems, or a free book on Sound Control, write Johns-Manville, Box 158, Department MH, New York 16, New York.

*Reg. U. S. Pat. Off.

See "MEET THE PRESS" on NBC-TV sponsored on alternate Sundays by Johns-Manville

JOHNS-MANVILLE JM PRODUCTS

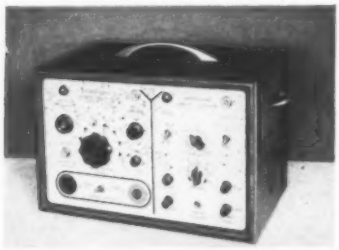
Johns-Manville

45 years of leadership in acoustical materials

WHAT'S NEW

Cardiac Arrest and Fibrillation Handled by One Instrument

The Electrodyne E-11 is a new instrument providing detection and treatment



of both cardiac arrest and ventricular fibrillation in the one unit. A combination of the Electrodyne D-72 external defibrillator and the Electrodyne Cardiac Pacemaker, the new electronic unit is designed for use in surgery. Developed for clinical treatment of ventricular fibrillation and persistent ventricular tachycardia through the unopened chest by the defibrillator, it also supplies external stimulation to the heart in cardiac asystole due to anesthesia, disease or other cause, through the Cardiac Pacemaker. Automatic electric stimulus is provided until cardiac activity returns. The combination unit permits quick action in cardiac emergencies during surgery. **Electrodyne Co., Norwood, Mass.**

For more details circle #204 on mailing card.

Hypo Brush Cleans Needles and Syringes

An all-purpose cleaning brush for hypodermic needles and syringes is offered in the Hypo-Brush. Consisting of three brushes in one, it has a nylon bristle brush especially formed to reach all inside surfaces of the syringe barrel, corrugated nylon stylettes in different gauges to clean the inside surface of the luer tip, either glass or metal, and a small natural bristle brush shaped to reach the inside surface of the hub of the needle. The Hypo Brush, used with a good detergent, facilitates the preparation of sterile, freely operating syringes and needles with minimum effort. **General Medical Equipment Corp., 9 Cleveland St., Valley Stream, N.Y.**

For more details circle #205 on mailing card.

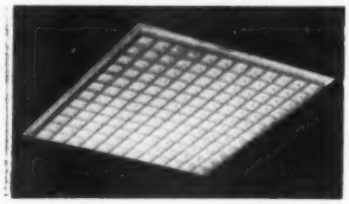
"Diamond Edge" Scissors Stay Sharp

A line of surgical scissors with tungsten-carbide cutting edges is offered in the "Ochsner Diamond Edge" Scissors. This extremely hard metal is permanently built into the cutting edge of the scissors. The result is extraordinary resistance to wear and extremely long periods of use without dulling. **Snowden-Pencer Corp., P. O. Box 186, Los Gatos, Calif.**

For more details circle #206 on mailing card.

CurtiCell Louver-Diffuser Reduces Glare

Over two years of research and development work in lighting fixtures resulted in the new CurtiCell plastic enclosure. The new louver-diffuser controls direct glare by the louver, and reflected glare is reduced by the frosted top panel. In the shielding zone the light rays pass through four or more thicknesses, producing a soft, efficient illumination without distracting brightness. The basis of CurtiCell is a frosty, plastic top panel electronically fused to a molded plastic, cellular bottom. The cellular piece may be of either a translucent white or a clear plastic with a



frosted finish. CurtiCell is light in weight and made of shatterproof, self-extinguishing vinyl chloride for maximum safety. The unit can be washed in luke warm mild detergent solution. **Curtis Lighting, Inc., 6135 W. 65th St., Chicago 38.**

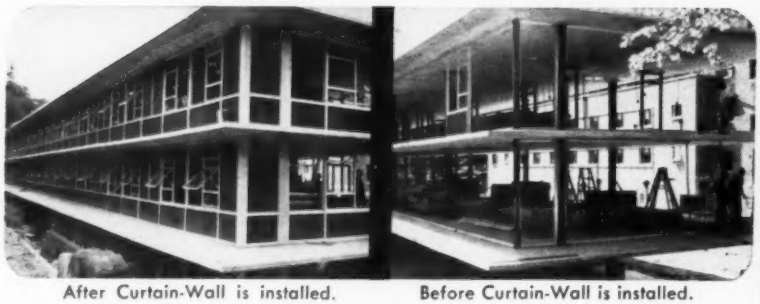
For more details circle #207 on mailing card.

(Continued on page 218)

How to simplify and cut costs of Your wall construction with

BAYLEY

CURTAIN WALL SYSTEMS



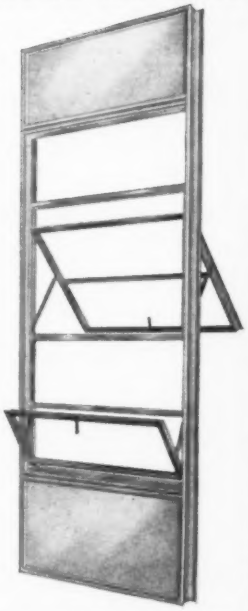
After Curtain-Wall is installed. Before Curtain-Wall is installed.

—incorporating BAYLEY Projected Windows and Decorative Panels

Bayley Curtain Wall Systems—in either aluminum or steel—offer you the maximum economies to be realized from modern curtain-wall construction. Incorporating standard time-proved Bayley Projected Window Units, and a Bayley system of sub-frame assembly, a designer's preference can be met without the costliness of special window designing. Also, as illustrated, installation is reduced to the simplest procedure. Other advantages accruing are:

- **Permits a choice of decorative panels and individualized arrangements**
- **Provides an insulated wall treatment to suit the building's appropriation**
- **Designed to accommodate a building's movement — expansion and contraction**
- **Provision against condensation annoyance or damage**
- **A wall with any desired degree of air, light or vision**
- **Centralized responsibility for the complete wall system — including sub-frames, windows and panels**

For further information write; or call your local Bayley Representative; or see Sweets.



The Bayley Series A-450 Aluminum Curtain-Wall Unit.

Write Today for this Curtain-Wall Idea File.

1. Bolting sill and header plate into position.
2. Bolting jamb plate to load-bearing column.

3. Interlocking window-panel into position.

4. Caulking interlock grooves before positioning mullion.
5. Positioning Bayley adjustable-width mullion.
6. Positioning window-panel — using interlock groove as slide.

THE WILLIAM BAYLEY COMPANY

Springfield, Ohio

District Sales Offices: Springfield Chicago 2 New York 17 Washington 16

Vacuum Cleaner Has Portable Bag

A new Hild vacuum cleaner is now available with a transferrable head and an outside bag. The maintenance man

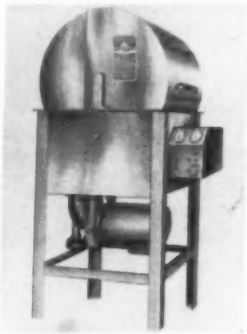
can detach the unit from the larger tank and strap it to his shoulder for use in cleaning venetian blinds, furniture, walls and other areas. The new unit features increased air volume and high speed. The head with the attached bag is available with or without the 55 gallon tank or the four wheel ball bearing dolly. **Hild Floor Machine Co., Inc., 740 W. Washington Blvd., Chicago 6.**

For more details circle #208 on mailing card.

Counter Type Dishwashing Machine for Universal Use

The new Model T-6—T-6A Champion Dish Washing Machine is a counter type machine designed for universal use. The roll hood type Champion is available for both automatic and semi-automatic operation and has a capacity of 640 dishes per hour. It can be installed on the dish table, under the counter or mounted on a stand. In addition to its use in smaller operations, it can also be used as an auxiliary unit to a large installation.

Powerful new wash and rinse sprays located above and below the rack give the new model efficient operation and a Dwell Control can be used for prolonged washing for stubborn soil. Timing of



each rack in both washing and rinse sprays is automatically regulated for assured sanitation of dishes and glassware. **Champion Dish Washing Machine Co., Erie, Pa.**

For more details circle #209 on mailing card.

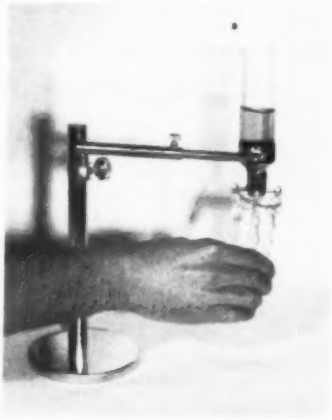
Correction Seal for Key-Punch Errors

Super-thin seals that stick without moistening are now available for plugging key-punch errors. The permanent Brady Correction Seals are mounted on a handy dispenser card for fast application in case of error, 216 per card. The seals are not affected by humidity or storage, cannot dry out or fall off corrected cards, according to the manufacturer, and register as corrections in the verifier. Both transparent and opaque red seals are available. **W. H. Brady Co., 727 W. Glendale, Milwaukee 12, Wis.**

For more details circle #210 on mailing card.

Royco Graviometer Saves Technician's Hands

Specific-gravity measurements of acids, milk, spirits, urine and other liquids can be made rapidly in the laboratory with the new Royco Graviometer. The technician's hands need not come into contact with the fluid in using the device. The liquid is discharged after reading



by upward pressure on the stainless steel valve which can be rotated into lock-open position for periodic flushing and cleaning. The weighted base supports the extensible arm and a 25 or 38 mm diameter glass vessel is held in accurately vertical position. The hydrometer reading is taken when the vessel is filled to overflow. **Royco Instruments, 853 Arthur St., Albany, Calif.**

For more details circle #211 on mailing card.

Ice Melting Material Harmless to Pavements

Ice Rem-CF is a chemically active, chloride-free ice and snow melting material. It does not produce a heat effect and is said to be harmless to pavements, metals and vegetation. It is designed to thaw ice and snow quickly on steps, walks, streets, gutters and drains and to be effective at low temperatures. **Speco, Inc., 7308 Associate Ave., Cleveland 9, Ohio.**

For more details circle #212 on mailing card.

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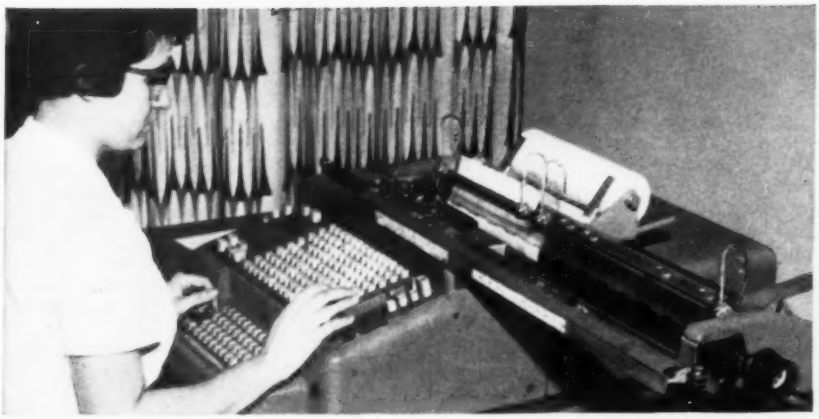
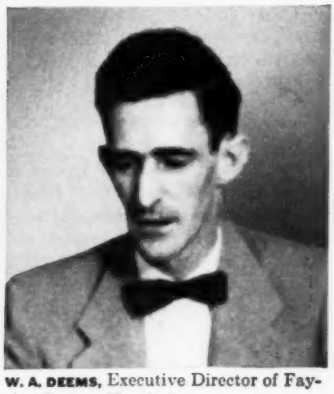


PATIENTS' STATEMENTS, general ledger, payroll—all are posted rapidly on this National "31."

THIS NATIONAL REMITTANCE CONTROL MACHINE gives quick, accurate totals.

MODERN Fayette County Hospital uses an efficient National System.



W. A. DEEMS, Executive Director of Fayette County Hospital.

"Our *National* System repays its cost every 18 months

a 67% annual return on our equipment investment!"

—The Fayette County Hospital
Vandalia, Ill.

"Ever since we installed our National System, our entire accounting operation has run smoothly and up-to-date," writes W. A. Deems, Executive Director of the Fayette County Hospital. "Our Nationals save us many hours each week and have reduced operating costs significantly.

"We use a National 'Class 31' for all our posting and proving work. This includes payroll, patients' accounts, general ledger, and other general bookkeeping functions. Both our '31' and our National Remittance Control Machine have eliminated all mistakes in addition and provide us with valuable information and control.

"In terms of time-savings and control, our National System repays its cost every 18 months—a 67% return on our equipment investment. We have complete confidence in our Nationals and recommend them highly!"

W. A. Deems
Executive Director

A complete, modern National System can save time and money in your hospital, too. Nationals pay for themselves quickly, then continue savings as extra yearly profit. For full information, call your nearby National representative today. His number is in the yellow pages of your phone book.

THE NATIONAL CASH REGISTER COMPANY, Dayton 9, Ohio
989 OFFICES IN 94 COUNTRIES

* TRADE MARK REG. U. S. PAT. OFF.

National*
ACCOUNTING MACHINES
ADDING MACHINES • CASH REGISTERS

WHAT'S NEW

Pharmaceuticals

Selsunef Ointment

Selsunef Ointment is a dermatologic preparation indicated for treatment of marginal belpharitis, seborrheic dermatitis of the auditory canal and other limited areas of the body, and for allergic dermatoses where seborrheic involvement is suspected. It is supplied in 5 Gm tubes, each containing selenium disulfide and hydrocortisone acetate in a soft petrolatum base. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #213 on mailing card.

Cathocillin

Cathocillin offers the advantages of dual antibiotic therapy by combining Cathomycin with penicillin in a single dosage form. It covers gaps presented by either antibiotic alone and proves effective against a larger number of commonly occurring infections. **Merck, Sharp & Dohme, Philadelphia 1, Pa.**

For more details circle #214 on mailing card.

Tetrex

Tetrex is a new broad-spectrum antibiotic compound with fast, efficient action. It is a single antibiotic providing high blood levels within one to three hours of administration. It is described as an entirely new salt of tetracycline that raises blood levels from a single oral dose to practically double those from an equal dose of tetracycline hydrochloride, acting quickly with continued high levels over a 24-hour period. It is available in capsule form in bottles of 16 and 100. **Bristol Laboratories, Inc., 630 Fifth Ave., New York 20.**

For more details circle #215 on mailing card.

Sigmamycin

Sigmamycin is a new synergistically strengthened multi-spectrum antibiotic formulation providing high therapeutic effectiveness, maximum protection against resistance and safety and tolerance. It is designed to provide superior control of infectious diseases through control of the changing microbial population. It is supplied in bottles of 16 and 100 250 mg. capsules. **Pfizer Laboratories, 630 Flushing Ave., Brooklyn 6, N. Y.**

For more details circle #216 on mailing card.

Cerofort Drops

Cerofort Drops provide an effective means of stimulating appetite and promoting weight gain in infants and children with poor eating habits. By combining the essential amino acid, lysine, with therapeutic doses of B vitamins, Cerofort Drops are said to improve the tissue building quality of the diet and the quantitative intake of food. **White Laboratories, Inc., Kenilworth, N.J.**

For more details circle #217 on mailing card.

Cantil

Cantil is an anticholinergic specifically for the relief of pain, cramps and bloating in functional and organic colon disorders. It is described as avoiding widespread autonomic disturbance and to be unusually free of antispasmodic side effects, such as urinary retention, dry mouth and blurred vision. Cantil is supplied plain in bottles of 100, scored, 25 mg. tablets. With phenobarbital it is supplied in bottles of 100 tablets, 25 mg. of Cantil and 16 mg. of phenobarbital. **Lakeside Laboratories, Inc., 1707 E. North Ave., Milwaukee 2, Wis.**

For more details circle #218 on mailing card.

Colace Syrup

Colace, the dioctyl sodium sulfosuccinate stool-softener, is now available in syrup form, providing dosage forms for administration to patients of all ages. The new syrup is orange-mint flavored, each teaspoonful supplying 20 milligrams of the stool-softener. Colace is now available in the original 50 mg capsules, a one per cent aqueous drop dosage solution, the syrup, and in 100 mg capsules for management of difficult cases. The non-laxative wetting agent reduces the surface tension of intestinal fluids to allow penetration and softening of the stool. **Mead Johnson & Company, Evansville 21, Ind.**

For more details circle #219 on mailing card.

(Continued on page 222)

WHAT'S NEW

Literature and Services

• The **S.K.F. Film Center** has been established by Smith, Kline & French Laboratories, 1530 Spring Garden St., Philadelphia 1, Pa., to produce and distribute medical films for showing at hospital staff, medical society and similar meetings. Four films currently available from the Film Center are described in a brochure now available from the company.
For more details circle #220 on mailing card.

• **"How to Remove Stains from Floors"** is the title of a new booklet issued by Huntington Laboratories, Huntington, Ind. The booklet lists steps for general stain removal from all floors and then gives instructions for specific floors.
For more details circle #221 on mailing card.

• **Composite Catalog No. 203A** lists all standard pan and tray sizes, along with their actual dimensions, in the complete Cres-Cor line of aluminum food service equipment. The two types of side-wall construction used by Cres-Cor, corrugated and angle-ledge, are graphically illustrated. Fifty-four typical units of the complete line of 260 models are illustrated and all sizes of cabinets, racks, tray carts and vertical carts are pictured. Copies of the catalog are available from Crescent Metal Products, Inc., 18901 St. Clair Ave., Cleveland 10, Ohio.
For more details circle #222 on mailing card.

• The new line of **Specialty Surgical Instruments** developed by American Cystoscope Makers, Inc., 1241 Lafayette Ave., New York 59, is illustrated and described in a new 20-page catalog now available from the manufacturer.
For more details circle #223 on mailing card.

• A new catalog of tables and stools for lunchrooms and cafeterias as well as Sani-Dri electric hand dryers is offered by The Chicago Hardware Foundry Co., North Chicago, Ill. Entitled **"Designs in Color,"** the catalog is printed in attractive colors as well as black and white.
For more details circle #224 on mailing card.

•**G.E.'s Intra-Tel Closed Circuit Television System** is described in **Bulletin ECL-53** available from General Electric Co., Electronics Park, Syracuse, N.Y. Details on the camera, monitor, control unit and accessories are included along with typical arrangements and complete specifications.
For more details circle #225 on mailing card.

• **"Step Lively and Lose Weight"** is the title of a new folder available from The American Dietetic Assn., 620 N. Michigan Ave., Chicago 11. Low-calorie meal patterns, suggested amounts of various foods to be used and a sample 1200 to 1800 calories per day menu is included.
For more details circle #226 on mailing card.

• The place of turkey in relation to high protein content is told in a new booklet, **"Turkey . . . Highest in Protein, Low in Fat,"** prepared by The National Turkey Federation, Mt. Morris, Ill. It discusses and compares the nutrient composition as well as the protein and energy content of turkey with various other meats and shows how turkey meets the nutritional needs of institutions.
For more details circle #227 on mailing card.

• A new edition of the **Progressive Food Service Equipment Manual** has been prepared by Progressive Metal Equipment, Inc., Rhawn St. at Whitaker Ave., Philadelphia 11, Pa. Comprised of four sections, the catalog describes Expan-O-Unit interchangeable backbars, water coolers, cafeteria counters and kitchen equipment.
For more details circle #228 on mailing card.

• The complete line of **Detroit Diesel Electric Generator Sets** has been outlined in a new brochure obtainable from Detroit Diesel Engine Div., 13400 W. Outer Dr., Detroit 28, Mich. Specifications and illustrations cover over 25 models ranging from 20 to 245 KW.
For more details circle #229 on mailing card.

• A new catalog of **"Films for Nursing and Health"** is now available through the ANA-NLN Film Service, 2 Park Ave., New York 16.
For more details circle #230 on mailing card.

(Continued on page 224)

• The story of phone dictation is told in a 16-page booklet entitled **"That New Fashioned Phone Dictation System Is Edison Televoice."** Published by Thomas A. Edison, Inc., West Orange, N.J., the brochure discusses such subjects as "Why Instrument Dictation," "Why Phone Dictation" and "The Simplicity, Speed, Versatility, Economy and Appeal of the Televoice System," with details on the units comprising the system.

For more details circle #231 on mailing card.

• **"Are You Building or Remodeling?"** is the title of a folder released by Western Underwriters Assn., 175 W. Jackson Blvd., Chicago 4. It includes an invitation to submit building plans for review, without cost or obligation, on which suggestions will be made with a view toward obtaining the lowest possible fire insurance cost.

For more details circle #232 on mailing card.

• A new documentary film about the aged, **"A Place to Live,"** was produced to provide better understanding of this subject for the medical profession, geronotological groups and the public. The 16 mm black and white sound film has a running time of 24 minutes and is available on loan from The Wm. S. Merrell Co., Geriatric Film Library, Cincinnati 15, Ohio.

For more details circle #233 on mailing card.

• **"The Story Behind A Bottle"** is the title of a new 24-minute motion picture telling the story of glass containers and their development. The film, photographed in Eastman color and presented in narrative style, goes back to the earliest known glass containers made in Egypt about 1800 B.C. and brings the story down to the present time. Prints of the film are available in both 16 and 35 mm from the Glass Container Manufacturers Institute, Inc., 99 Park, New York 16.

For more details circle #234 on mailing card.

• The story of the **"Flexalarm Fire Alarm System"** is told in **Bulletin No. F249, Flexalarm Section II, Technical,** available from The Gamewell Company, Newton Upper Falls 64, Mass. The Flexalarm Manual states that "The name Flexalarm is applied to a complete line of fire alarm components designed to comply with the recommendations of the various Federal, National and State authorities concerned with the approval and operation of fire alarm facilities." The bulletin contains technical data on the entire line and its component parts.

For more details circle #235 on mailing card.

• The Building Construction Employers' Association, 228 N. La Salle St., Chicago 1, has published a booklet on **"True Efficiency in Building"** for use by architects and administrators contemplating building programs. The booklet contains a check list on the various phases of a construction program and answers 20 questions on building.

For more details circle #236 on mailing card.

Suppliers' News

Diamond Crystal Salt Co., St. Clair, Mich., producers of salt, announce the acquisition of the controlling interest in the **Jefferson Island Salt Co., Louisville, Ky.** It is announced that the Jefferson Island company will be operated as an independent division of Diamond Crystal Salt Co.

Hillyard Chemical Co., St. Joseph, Mo., manufacturer of floor treatment and floor maintenance products, announces the opening of a new six-story **Hillyard office building** in St. Joseph, Mo. Dedication of the new building will coincide with the company's 50th anniversary celebration during January.

Farley Manning Associates, 270 Park Ave., New York 17, public relations agency for the **Paper Cup and Container Institute, Inc.,** announces the availablity of a **food facilities planning service** for administrators of hospitals, schools, colleges, architectural firms and others concerned with food service. The new service is designed to assist those responsible for large-scale food service to effect economies in building and operating kitchens which are possible with the use of modern paper service products.

Meterflo Dispensers, formerly of **627 Grove St., Evanston, Ill.,** manufacturer of a complete line of stainless steel cabinet dispensers, floor and counter models for the automatic portion controlled delivery of bulk milk, fruit juices and other refrigerated liquids, announces the opening of new offices and company headquarters at **2534 S. 11th St., Niles, Mich.**

Radio Corporation of America, 30 Rockefeller Plaza, New York 20, announces the establishment of a **Technical Research Service** to provide users of electron microscopes with qualified assistance in the solution of medical, biological and industrial microscopy problems. John J. Kelsch is the scientist in charge of the new service.

Syracuse China Corporation, Division of Onondaga Pottery Co., 1858 W. Fayette St., Syracuse 4, N.Y., is the new name style for this manufacturer of Syracuse China. The change has been made to avoid confusion in the use of the brand name of Syracuse China which has been produced by Onondaga Pottery Company for more than sixty years.

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Armstrong Cork Co.

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168 Time Labels and Dispensers
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